

1 IN THE CIRCUIT COURT OF DESOTO COUNTY, MISSISSIPPI
2
3 KAY T. NUNNALLY, INDIVIDUALLY
4 AND ON BEHALF OF ALL WRONGFUL
5 DEATH BENEFICIARIES OF JOSEPH
6 LEE NUNNALLY, DECEASED PLAINTIFF

7 V. CIVIL ACTION NO. CV92-270-CD
8
9 R. J. REYNOLDS TOBACCO
10 COMPANY AND BASIC FOODS, INC. DEFENDANTS

11 VOLUME 9
12 DAILY COPY TRIAL PROCEEDINGS

13 DATE: July 7, 2000

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1 JUDGE CARLSON: We should have water for
2 the next few minutes, anyway. The water cut on.
3 The pressure is building back up.
4 (Jury enters courtroom.)
5 JUDGE CARLSON: All right. Ladies and
6 gentlemen. We're ready to go. The delay was caused
7 by me. I was talking to the contractor trying to
8 find out about the water. Quite frankly, I don't
9 know whether or not all of you were able to get into
10 the restroom since there's no water pressure to be
11 able to flush the commode. So if you need a break
12 quicker than normal, just let me know, and we'll
13 stop at any time, and hopefully by that time, the
14 pressure will be back. The contractor told me, it's
15 been at least five minutes since I talked to him.
16 They have to cut the water back on
17 gradually and he thought it would take another 15 or
18 20 minutes for the pressure to build up
19 sufficiently. So somewhere along the way if you
20 need a break before the normal time, just get my
21 attention, we can do that.
22 Since you've had the overnight recess, I
23 need to find out if you've had occasion to talk with
24 anyone about the case, or has there been any effort
25 on the part of anyone to talk to you about the case,

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1 any outside information gained about the case,
2 anything you need to bring to my attention?
3 I take it there's been no contact or
4 discussion. We'll move forward at this time.
5 Mr. Liston.
6 MR. LISTON: We'd like to call a
7 Mr. Guyton Nunnally, please. Your Honor,
8 Mr. Nunnally is the brother of the decedent, and
9 we'd like to call him in an adverse posture.
10 JUDGE CARLSON: All right. You can come
11 around and let the clerk swear you in.
12 GUYTON NUNNALLY,
13 having been first duly sworn, was examined and
14 testified as follows:
15 DIRECT EXAMINATION BY MR. LISTON:
16 Q. How are you, Mr. Nunnally?
17 A. I'm fine.
18 Q. My name is Bill Liston. I don't believe
19 we've met before right now, have we?
20 A. That's true.
21 Q. All right, sir. I'm going to be asking
22 you some questions this morning, and your deposition

23 was previously taken in this case; is that correct?

24 A. That's correct.

25 Q. I have a copy of it. If at any time you

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1 need to refresh your recollection about events or
2 things that were asked you in that deposition, let
3 me know, and I can give you a copy of the
4 deposition.

5 A. All right, thank you.

6 Q. All right, sir. Thank you. Would you
7 state your full name, please, sir?

8 A. James Guyton Nunnally, III.

9 Q. What's your date of birth, Mr. Nunnally?

10 A. March 27th, 1948.

11 Q. Where do you presently live?

12 A. [DELETED].

13 Q. And what is your job or occupation?

14 A. I'm the sales manager for a photographic
15 and digital imaging company in Memphis.

16 Q. What was your relationship to Mrs. Marion
17 Nunnally and James C. Nunnally, Jr.?

18 A. James C. or James G.?

19 Q. James G., excuse me, you're right.

20 A. I'm their oldest son.

21 Q. And your father, James G., is deceased;
22 is that correct?

23 A. That's correct.

24 Q. When did he die, Mr. Nunnally?

25 A. Last year, July of last year.

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1 Q. And your mother, Mrs. Marion Nunnally, is
2 still living?

3 A. That's correct.

4 Q. You were the oldest child of that family,
5 I believe; is that correct?

6 A. That is right.

7 Q. And you were born in 1948?

8 A. That's correct.

9 Q. And Ben, your next brother, was born in
10 1950; is that correct?

11 A. I believe that's correct, yes.

12 Q. And Mr. Joseph Nunnally was born in 1952?

13 A. Uh-huh, June.

14 Q. Two years separated each one of you?

15 A. That's correct.

16 Q. Is that correct?

17 A. Uh-huh, uh-huh.

18 Q. Where did you attend elementary school,
19 Mr. Nunnally?

20 A. Well, prior to moving to Horn Lake in
21 1959, I went to elementary school in Memphis,
22 Longview Heights, but I started the 6th -- 6th grade
23 at Horn Lake in '59, I believe.

24 Q. And that's when your family moved from
25 Memphis to [DELETED]?

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1 A. That's right, that's right, Horn Lake.

2 Q. Horn Lake, excuse me. Did Ben and Joe
3 eventually attend the same school that you attended?

4 A. Right, that's correct.

5 Q. If you were in the 6th grade when you
6 moved, then Ben -- both Ben and Joe would have been
7 in the school when you moved down here --

8 A. That's correct.
9 Q. -- is that correct? You lived with your
10 parents from the time here in Horn Lake, you lived
11 with your parents from the time you moved until you
12 graduated high school?
13 A. That's correct.
14 Q. What year did you graduate high school?
15 A. In 1966.
16 Q. And all that time, Ben -- that chair is a
17 little tricky there. All that time, Ben and Joe
18 were attending Horn Lake High School or --
19 Elementary School or high school, correct?
20 A. That's right.
21 Q. What was the first time that you saw your
22 brother, Joe, smoking a situating cigarette,
23 Mr. Nunnally? About what age? I'm not talking
24 about a date.
25 A. 15, 16, in that age.

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1 Q. I believe you testified that you never
2 saw Joe smoke a cigarette at any time before the
3 time that you've just told us; is that correct?
4 A. Not that I can recall, that's correct.
5 Q. All right, sir. After you graduated from
6 high school, you were actually absent from the
7 family home for quite some time, were you not?
8 A. Basically, that's true, yes.
9 Q. And when did you -- I know that you moved
10 to Florida, and then you were in the service?
11 A. That's correct.
12 Q. And then, eventually, you came back to
13 Mississippi?
14 A. That's right, uh-huh.
15 Q. About 1980?
16 A. Well, if you're talking that little time
17 frame, I really came back after -- after the Navy,
18 which was about 1971, '72, stayed for a while. We
19 moved to Atlanta, and we came back to Atlanta in
20 about 1980.
21 Q. And when you came back from Florida, you
22 lived at home for a while and attended Northwest
23 Community College?
24 A. That's correct.
25 Q. Was Joe living at home then?

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1 A. I believe so, yeah.
2 Q. And how long did you live at your home
3 during that period of time?
4 A. Not -- not very long. We had a fairly
5 small home, and it was a little crowded.
6 Q. As I understand your testimony, during
7 the period of time that you were in high school or
8 elementary school from the time that you moved back
9 here to Memphis with your family, you lived in the
10 home with your brother, Joseph; is that correct, up
11 until you graduated from high school?
12 A. Yes, uh-huh.
13 Q. Which was 1966.
14 A. That's right.
15 Q. And during that period of time, you never
16 saw Joseph smoke a cigarette, did you?
17 A. I don't recall seeing him smoke a
18 cigarette.

19 Q. Do you recall telling us in your
20 deposition that you did not see him smoke a
21 cigarette?

22 A. Yeah, I read the deposition a couple of
23 times, and that's what I did say, you know.

24 Q. And that the first time that you did see
25 him smoke a cigarette was when he was about 15 years
2029 age -- of age?

2 A. Is that what I said in the deposition?

3 Q. After you came back in the '80s, would
4 you describe your relationship with your brother,
5 Joseph?

6 A. Well, it was -- it was more of a
7 friendship relationship than I think brothers,
8 because we had been apart such a long time. We just
9 kind of made a new friendship at that time.

10 Q. And I believe you characterize it as,
11 really, you had the opportunity to become closer to
12 him during this period of time than you ever had
13 before that?

14 A. That's right, that's right.

15 Q. From 1980 up until his unfortunate death,
16 Mr. Nunnally, you were in a position to -- because
17 you were closer to him, to know him pretty well as a
18 person, is that -- is that a fair statement?

19 A. Well, I knew him more as a person than I
20 had at a previous time.

21 Q. How would you describe Joe's attitude
22 toward personal responsibility during that period of
23 time?

24 A. I would -- I would say that he took his
25 personal responsibility very seriously.
2030

1 Q. Would you say that he took responsibility
2 for his own actions?

3 A. Yes.

4 Q. Was he a determined, strong-willed person
5 during this period of his life?

6 A. Yes.

7 Q. I believe you told us previously that Joe
8 was the type person that if he put his mind to
9 something, he could pretty well do it; is that
10 correct?

11 A. That's right.

12 Q. Is that a fair --

13 A. That's a fair assessment.

14 Q. -- statement about Joe?

15 A. Yes.

16 Q. When you were living in the home, would
17 you tell us what your mother and father's smoking
18 practices were? Did they smoke?

19 A. Yes, they smoked.

20 Q. Did your father, to your knowledge, ever
21 quit smoking cigarettes?

22 A. Yes, he did quit, uh-huh.

23 Q. And when was that?

24 A. I think he was probably late 50s, early
25 60s, his age.
2031

1 Q. That would have been in the '80s or
2 earlier than that?

3 A. It could be earlier than that. I can't

4 really do the arithmetic in my head right now.
5 Q. That's fine. As you recall, with his he
6 able to quit, what we say "cold turkey"?
7 A. No, he was not able to quit cold turkey.
8 Q. Tell us about how he managed to quit.
9 A. Well, it was the a struggle for him,
10 because he had smoked all of his life. And he had
11 smoked very heavy cigarettes, Camels, unfiltered.
12 Q. Did he have to seek professional advice,
13 or did he do it on his own?
14 A. Not that I know of. I think he did it on
15 his own.
16 Q. Do you know whether or not he had to
17 resort to nicotine patches, or nicotine gum,
18 anything like that in order to stop smoking?
19 A. Again, I'm not -- I'm not sure. I
20 don't -- I don't know.
21 Q. Your mother was a smoker also, I believe
22 you had told us.
23 A. That's correct.
24 Q. And she quit also, didn't she,
25 Mr. Nunnally?

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1 A. Yes.
2 Q. Did she quit, just cut it off and stop?
3 A. I would say that she had an easier time
4 of it than my father did.
5 Q. And I'll ask you the same questions about
6 what she did to stop smoking. Did she have to seek
7 professional help to do that?
8 A. Not that I know of.
9 Q. Did she have to use any aids for a long
10 period of time in order to stop smoking?
11 A. Not -- not that I really know of.
12 Q. All right. And Joe, himself, quit
13 smoking right before his operation in February of
14 1989, didn't he, Mr. Nunnally?
15 A. I -- I don't know that.
16 Q. You don't know that. All right, sir.
17 After he got back from Houston, Texas, after this
18 operation, from that time up to his death later in
19 the year, you visited him, saw him and was around
20 him, were you not, when he came back home?
21 A. Yes, but not very often.
22 Q. Did you ever see him smoke during that
23 period of time?
24 A. Not that I recall.
25 Q. All right. When you were in the family,

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1 and living at home and Joe was there, were you
2 familiar with the terms "cancer sticks" and "coffin
3 nails" referring to cigarettes?
4 A. I had heard those terms.
5 Q. Did you know what -- what that meant?
6 What the --
7 A. Well, from hanging around people at
8 school and just whatever. Yes, I -- I knew what
9 that was.
10 Q. Were those terms commonly used in school?
11 A. I think they were used everywhere. They
12 were used in the media, at school.
13 Q. Was Joe exposed to those terms?
14 A. I would think so.

15 MR. MERKEL: Objection, Your Honor, calls
16 for speculation on the part of that witness.

17 MR. LISTON: If he knows.

18 JUDGE CARLSON: Yes, sir, it can be
19 rephrased.

20 MR. LISTON: Okay.

21 Q. (By Mr. Liston) Did you ever hear Joe
22 use those terms?

23 A. Not that I recall.

24 Q. Did Joe ever tell you that he tried to
25 quit smoking cigarettes before February of 1989, but
2034

1 he just couldn't?

2 A. We more than likely had conversations
3 about that, but I don't recall him saying that he
4 just absolutely could not quit.

5 Q. Well, back in your -- when you gave your
6 deposition, if you'd like to look at it, I'd show
7 you -- at page 20, Mr. Merkel -- and you told us
8 that Joe, as I read it, never told you that he tried
9 to the quit earlier but couldn't. Does that refresh
10 your recollection? And I can give it to you if you
11 want.

12 MR. MERKEL: Your Honor, I'd ask the
13 witness review his deposition, if he's going to be
14 asked about it instead of counsel paraphrasing
15 something.

16 MR. LISTON: I'll be glad to.

17 JUDGE CARLSON: All right, sir.

18 Q. (By Mr. Liston) I think it's on page 20,
19 Mr. Nunnally.

20 A. What line?

21 Q. Give me just a second, and I'll try to
22 get there. On line 4, the question was: "Did he
23 ever say, 'Guyton, you know, I can't quit, I can't
24 give them up, ' do you ever remember him saying
25 anything like that?" And what was your answer?
2035

1 A. "I don't recall."

2 Q. What was the -- I don't recall, and what
3 else is your answer there?

4 A. "No."

5 Q. Okay. Thank you. Did Joe ever say
6 anything to you about after he was diagnosed with
7 cancer about filing a lawsuit against the tobacco
8 companies?

9 A. No.

10 MR. LISTON: Just one second.

11 Q. (By Mr. Liston) Mr. Nunnally, do you
12 still have -- turn back to page 20 there and let me
13 ask you this question. On line 17, I want to ask
14 you the same question today that we asked you then,
15 and that question was: "Was Joe Nunnally, was he
16 aware of the health risks that had been associated
17 with smoking?" And would you read your answer,
18 please?

19 MR. MERKEL: And again, Your Honor, I
20 object except to the extent he may know. He can ask
21 him a question of something he knows, but not what
22 he assumes. And I don't think you can read another
23 person's mind as to what they're aware of.

24 JUDGE CARLSON: He can respond to his
25 knowledge when you cross examine him.

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1 Q. (By Mr. Liston) What did you tell us
2 then?

3 A. Do you want me to read it from here?

4 Q. Yes, sir.

5 A. "I would think that he would have been
6 aware as most of us are. I don't see where he would
7 be isolated to that information."

8 MR. LISTON: All right. Thank you, sir.
9 Thank you.

10 JUDGE CARLSON: Cross examination,
11 Mr. Merkel.

12 CROSS EXAMINATION BY MR. MERKEL:

13 Q. Mr. Nunnally, while you still have that
14 deposition open, let's go ahead and finish the
15 answer that you gave. I guess this one is to -- I'm
16 not sure which one of the lawyers deposed you. It
17 wasn't Mr. Liston, I know. Mr. Ulmer, the gentleman
18 seated here, is he the one that took your
19 deposition, this one right here? Don't remember?

20 A. I don't recall.

21 Q. Let's go on down through the rest of page
22 20 and on through page 21 reading your questions and
23 answers, Mr. Guyton. Let's start with the one you
24 already read, question: "Was Joe Nunnally, was he
25 aware, was he aware of the health risks associated

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1 with smoking?" If you'll just read your answer?

2 A. "I would like to think he would have been
3 aware as most of us are. I don't see where he would
4 have been isolated to that information."

5 Q. "And the health risks that have been
6 associated with smoking, among other things, are
7 lung cancer, do we agree with that?"

8 A. "Certainly appears to me" --

9 Q. "And this information" --

10 MR. LISTON: I think you cut him off.

11 A. "As admitted I think by the tobacco
12 companies as recently" --

13 JUDGE CARLSON: Mr. Liston.

14 MR. LISTON: Excuse me, Mr. Nunnally. I
15 believe Mr. Merkel cut off his answer on line 25.

16 MR. MERKEL: We're not even to line 25
17 yet. I'm on line 23 where I just read the question.
18 He's trying to the read the answer now.

19 MR. LISTON: Well, I thought he did read
20 it. May I ask that he read it?

21 JUDGE CARLSON: Let's back up, and you
22 can ask the question again, Mr. Merkel.

23 Q. (By Mr. Merkel) Let's start all over.
24 Let's start on line 22, read slowly. "And the
25 health risks that have been associate with smoking

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1 and, among other things, are lung cancer, do we
2 agree on that?" Your answer?

3 A. "Certainly appears to be, yes."

4 Q. "And this information" --

5 A. "As admitted I think by the tobacco
6 companies as recently --"

7 Q. And you were interrupted. "This
8 information of this awareness that you said that Joe
9 Nunnally would certainly have like the rest of us,
10 does that awareness go back to the late '60s or

11 early '70s with the Surgeon General's reports, and
12 the information that was regularly appearing in the
13 news media at that time?" And if you'd give your
14 answer, please?

15 A. "Well, I would think that, you know, when
16 the truth really started coming out and people
17 started delving into like the Surgeon General and
18 people wanted to start publicizing that this was
19 harmful to people's health. When they finally
20 contacted the huge, positive marketing campaign that
21 goes with the tobacco companies and the advertising
22 agency, I sort of forgot what your point was. But I
23 think that's when all started seeing. And when they
24 put the label on the cigarette packs and things like
25 that, of course, I think awareness increased at

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1 times as to what was going on."

2 Q. Now, Mr. Nunnally, if we assume, for sake
3 of the record right now, that Joe Nunnally started
4 smoking at eight years of age, which would have been
5 1960, I guess, and continued on smoking from that
6 point, what was the awareness that you were telling
7 Mr. Ulmer about that you had during this period of
8 time?

9 Say from 1960 forward, what were your
10 thoughts based on what you were delving from the
11 news, and the media and wherever the information was
12 coming from, you've said that you were aware of some
13 risks. If you'd just try to tell us what your
14 understanding was at '60 and moving on, as it
15 enlarged or grew or whatever the case.

16 A. Through the media, I was still fairly
17 young at that time. I don't think a that I was
18 reading news magazines and newspapers. But probably
19 just hearing it on a radio or whatever, that smoking
20 could be harmful to you if you did that.

21 Q. And you said something in here about the
22 "huge positive marketing campaign that goes on with
23 tobacco companies and advertising agents." As well
24 as hearing that it could be hazardous to your
25 health, what else were you hearing during this era?

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1 A. It was a cool thing to do.

2 Q. Did you ever hear a tobacco company admit
3 that it was dangerous or hazardous?

4 MR. LISTON: May want to the Court, we
5 object --

6 A. Not that I recall.

7 MR. LISTON: -- prior ruling of the
8 Court.

9 MR. MERKEL: Your Honor, again, he's the
10 one that raised what this gentleman knew, or heard
11 or thought.

12 JUDGE CARLSON: I'll overrule the
13 objection.

14 Q. (By Mr. Merkel) Did you ever read
15 anything where a tobacco company acknowledged yes,
16 it is going to cause cancer, yes, it is hazardous,
17 you shouldn't do it.

18 A. I haven't heard that really up until
19 today -- even today.

20 Q. This was an open question as far as you
21 were concerned from 1960 to 1966, Mr. Guyton?

22 A. Whether it was bad for you?
23 Q. Yes.
24 A. Yes, it was an open question.
25 Q. Tell us a little bit, Mr. Guyton, about
2041
1 your brother. They've asked you some things about
2 his being strong willed and all this, that and the
3 other. Tell us what kind of person he was as far as
4 the way he looked at his job, and his
5 responsibilities to his family and children and so
6 forth.
7 A. Well, he was -- he was a lovable --
8 lovable fellow as I -- as I think a lot of people
9 have contested to. He was hard working. He
10 progressed through the ranks of some very difficult
11 companies to be leaders in that company. Loved his
12 family, but he also liked to enjoy life.
13 Q. Was he a fun person to be around?
14 A. He was a great person to be around.
15 Q. Did his family enjoy his company to the
16 best you could observe?
17 A. To the best I could observe, yes.
18 Q. And your birthday was when in '48?
19 A. March 27th.
20 Q. So Joe is June of '52?
21 A. June 11th, '52, right.
22 Q. So four and a quarter, four-and-a-half
23 years difference or something in your ages. When
24 you're young, does four-and-a-half years make a lot
25 of difference in how much you run around with
2042
1 somebody?
2 A. Well, it did in our case. Sometimes it
3 doesn't, but in our case, it did.
4 Q. As far as following Joe around or knowing
5 Joe's day-to-day activities, how familiar were you
6 with those when you were in high school?
7 A. I didn't pay attention to Joe at all in
8 high school.
9 Q. You were an athlete, played sports and --
10 A. And other things, yes. I mean, he was a
11 little brother. I just didn't keep up with him.
12 Q. Do you have any idea at all when he first
13 began smoking?
14 A. I have no idea other than what I've
15 already testified to.
16 Q. That's the first time you remember seeing
17 him smoke in front of you?
18 A. Right, uh-huh.
19 Q. And you didn't smoke in front of your
20 parents, either?
21 A. No, huh-huh.
22 Q. So you wouldn't --
23 A. Not at a younger age.
24 Q. That's what I mean.
25 A. Right.
2043
1 Q. In other words, if Joe was smoking from 8
2 to 12, you wouldn't have expected him to do that in
3 front of them, either.
4 A. No.
5 Q. And you were -- when you went off to
6 school in 19, what, '66, is that when you graduated

7 from Horn Lake?
8 A. That's correct, uh-huh.
9 Q. So Joe would have been, at that time,
10 14-years-old?
11 A. Probably.
12 Q. And how long was it in the interval
13 before you came back to have any association with
14 him?
15 A. Well, from '60 -- from '66, it was
16 probably when I came back in '71 from the service, I
17 got to know him a little bit then. But really I
18 didn't get to know him until around 1980.
19 Q. So if you left school in June or so of
20 '66, Joe would have been, again, 14 -- just turned
21 14. Would you have seen him smoking before that
22 interval the first time?
23 A. I don't -- I don't believe so, no.
24 Q. Or was it five years later when you came
25 back that you first noticed he was?

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1 A. When I came back, I guess.
2 Q. Been a long time, hadn't it, Mr. Guyton.
3 Thank you, sir.
4 MR. LISTON: Just a few questions, Your
5 Honor.
6 REDIRECT EXAMINATION BY MR. LISTON:
7 Q. Mr. Nunnally, as I understand what you
8 just told Mr. Merkel, it would have really been when
9 you came back from the Navy that you first saw him
10 smoke a cigarette; is that correct?
11 A. That's right.
12 Q. And that was 1970?
13 A. Probably '71.
14 Q. '71. And Joe was born in '52, so that
15 would mean that he would be 19-years-old; is that
16 correct?
17 A. I think you could say so.
18 Q. When you first saw him smoke a cigarette?
19 A. As I recall.
20 Q. You played football and other sports at
21 Horn Lake?
22 A. That's right.
23 Q. And did you smoke while you were in high
24 school?
25 A. I might have dabbled around with it.

2045

1 Q. I believe you were a serious athlete and
2 you told us I believe, that your coaches and the
3 people in athletics there would discourage you
4 people from smoking; is that correct?
5 A. As all coaches do, I believe.
6 Q. Right, sir. Now, you were 12-years-old
7 when Joe was eight if I got my birthdays correct; is
8 that right?
9 A. I would say it's pretty close.
10 Q. And you were living in the home with Joe
11 at that time?
12 A. Uh-huh.
13 Q. And you continued to live with him for
14 the next six years until you got 18 and he would
15 have been 14, and you left; is that --
16 A. Right.
17 Q. -- is that correct?

18 A. Uh-huh.
19 Q. And at no time during that six years did
20 you ever see him smoke a cigarette; is that correct?
21 A. I don't recall.
22 Q. Okay, sir.
23 A. -- that.
24 Q. Did you ever smell tobacco on him during
25 that period of time?

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1 A. I never smelled Kool Aid on him, either.
2 Q. Well --
3 A. No.
4 Q. Is your answer "no," Mr. Nunnally?
5 A. No.
6 Q. He never told you he was smoking, did
7 he --
8 A. No.
9 Q. -- during that period of time?
10 MR. LISTON: I have nothing further. Oh,
11 wait just a second. Thank you.
12 JUDGE CARLSON: All right. Thank you,
13 Mr. Nunnally. All right. Ladies and gentlemen, let
14 me find out, any of you need a break before the next
15 witness? I'm not hearing anything. Okay. All
16 right. Mr. Liston.
17 MR. LISTON: May it please the Court, at
18 this time, we would like to have marked the
19 deposition of Miss Jenny Lee Hyde and read certain
20 portions of it to the jury.
21 MR. MERKEL: Your Honor, we object to the
22 deposition being read. Ms. Hyde is available, as
23 far as I know.
24 MR. LISTON: Well, she isn't available,
25 and Mr. Merkel should know that she's not available.

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1 MR. MERKEL: Well, I don't, Your Honor,
2 and I don't know of any basis for the deposition
3 being read. She's a local person according to the
4 deposition.
5 JUDGE CARLSON: If there's something that
6 needs to be taken up?
7 MR. LISTON: Yes, sir.
8 JUDGE CARLSON: I might as well take a
9 break and let you go to the restroom, and we'll get
10 you back after we get through.
11 (Jury exits courtroom.)
12 MR. MERKEL: Your Honor -- let me just
13 explain why I don't know what is on here, Bill.
14 MR. MERKEL: I've got a fax that
15 Mr. Liston hands me that's dated July the 5th, Your
16 Honor, and we've been up here since the evening of
17 July the 4th. I didn't get the fax, don't know
18 anything about what's in here. So that's why the
19 dispute about what I know about Ms. Hyde. I don't
20 know anything about it. And with that -- I mean,
21 I'll let Mr. Liston explain, and I didn't get the
22 fax and don't know what's in it.
23 JUDGE CARLSON: All right.
24 MR. LISTON: Well, I don't think we need
25 to go into that argument. Mr. Bell said that he

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1 delivered it to one of you by hand on Wednesday.
2 Let me just go over the chronology. Mrs. Hyde

3 was -- deposition was taken on October the 5th,
4 1999. Mr. Dodson was there present representing the
5 Plaintiff. And she answered questions under oath in
6 that deposition. Mr. Dodson chose not to ask her
7 any questions.

8 We had a subpoena served on Mrs. Hyde,
9 and I believe it was served maybe over the holiday
10 this week or early on Wednesday. After she was
11 served, Mrs. Hyde's husband called Mr. Bell and told
12 him that Mrs. Hyde had colon cancer. And that she,
13 on Wednesday, had just had a chemotherapy treatment.
14 We contacted, through Mr. Bell, her doctor, Your
15 Honor. And he has given a letter that we'd like to
16 mark as exhibit to this motion.

17 MR. MERKEL: I don't think so, Bill. I
18 haven't had anything -- I don't know. You'll have
19 to ask Jack. There are only two of us, but I've
20 never seen it.

21 MR. LISTON: And the letter, Judge, as
22 you can see, is from her doctor that says she is not
23 physically capable of traveling to and testifying in
24 court. And I don't know what happened to this
25 letter after it was delivered, but it was delivered,

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1 and I guess we better mark a copy of that letter.
2 Because --

3 (Exhibit 765 marked for identification.)

4 MR. LISTON: Your Honor, this deposition
5 is offered under Rule 32A3 of the Mississippi Rules
6 of Civil Procedure having to do with the use of
7 depositions. And that section says that they may be
8 used under certain conditions, one of which is that
9 the witness is unable to attend because of illness
10 or infirmities. It's not hearsay, Your Honor, under
11 Rule of Evidence 804B1 under the former testimony of
12 a witness not available.

13 And that provides the testimony given as
14 a witness at another hearing of the same -- I'm
15 going to leave out a little -- proceeding taken in
16 connection -- in compliance with law in
17 the course of the same proceeding, is it admissible
18 if, and not hearsay, if the witness is unavailable
19 and the opposing party had an opportunity to develop
20 the testimony by direct cross or redirect
21 examination. The deposition shows Mr. Dodson's
22 presence at that deposition.

23 We submit that we should be allowed to
24 produce Mrs. Hyde's testimony to the jury.

25 MR. MERKEL: Your Honor, the only

2050
1 question about is her availability. Obviously at
2 the deposition in this case, Mr. Dodson was there.
3 We chose not to cross examine any of these people.
4 I don't know a thing about her -- her condition.
5 We've not talked to her, not contacted her. She's
6 not contacted us.

7 So whatever the doctor's letter says,
8 whether it's possible for her to be here or not,
9 you're going to have to judge that. But if it's
10 going to be read, there's a portion of it, under the
11 circumstances, that we would ask that shouldn't be
12 admitted, because again, it's some of this innuendo
13 stuff that begins on page 14 with line 9. She's

14 asked a question, "Well, did you ever have Joe
15 Nunnally in one of your -- in your office with other
16 students when you talked about not smoking?"

17 JUDGE CARLSON: Excuse me, Mr. Merkel. I
18 don't see that designated in this letter. Line 9
19 says page 9, line 29 through page 14, line 3, and
20 then it picks up on page 17. I don't see --

21 MR. MERKEL: Let me get a designation,
22 Your Honor.

23 JUDGE CARLSON: Okay. Let me just go
24 ahead and state -- I need that letter back here.
25 Looking at the letter -- the letter that will be

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1 marked in a moment for purposes of the record is
2 Dr. Weir, W-E-I-R, dated July 5th, 2000, states
3 "Ms. Jenny Hyde is currently under my care for the
4 treatment of colon cancer. She completed a round of
5 chemotherapy Wednesday. She is not capable of
6 traveling to or testifying in Court. I request that
7 she be excused from her Court appearance."

8 So from the Doctor, the doctor's
9 professional opinion is this witness is unable to be
10 in Court. I think clearly it falls under rule 804B1
11 as to exception to the hearsay rule. And that also
12 that it meet the definition of availability --
13 unavailability of the witness asset out under 804A4
14 that the witness is unable to be present or to
15 testify at the hearing because of death or then
16 existing physical or mental illness or infirmity.
17 So proffered testimony clearly meets 804A4 and
18 804B1.

19 Likewise, -- that's in the rules of
20 evidence, of course, and then in Rule 32A3, the
21 Mississippi Rules of Civil Procedure, so the Court
22 will permit the portion to be read subject to having
23 to deal with any objections to the proffered
24 testimony as designated. Let's go ahead and take a
25 short break, and when we come back out, I'll see if

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1 there are any specific objections, and go forward.

2 (A short break was taken.)

3 JUDGE CARLSON: Anything to deal with at
4 this point?

5 MR. LISTON: We're marking it. We'll be
6 through in just a second.

7 MR. MERKEL: We're putting the
8 designations together, Your Honor. They're going to
9 read them all at once so there won't be any up and
10 down.

11 MR. LISTON: We're ready, Your Honor.

12 (Jury enters courtroom.)

13 JUDGE CARLSON: All right. Ladies and
14 gentlemen, we'll go forward at this time. The
15 Defendant may call its next witness.

16 MR. LISTON: May it please the Court,
17 we'd like to call by deposition Mrs. Jenny Lee Hyde
18 since she's unavailable because of illness.

19 JUDGE CARLSON: All right, sir. Again,
20 ladies and gentlemen, based on deposition testimony,
21 you've heard plenty about that, and the witness is
22 unavailable. And so the testimony that she gave on
23 a prior date by way of deposition will be read to
24 you.

25 MR. LISTON: Mrs. Hyde was sworn, and
2053
1 then the following questions and answers were given.
2 (Deposition of Jenny Lee Hyde read into
3 the record.)
4 MR. LISTON: That's all we have, Your
5 Honor, and we would like to mark a copy of this the
6 deposition for identification.
7 JUDGE CARLSON: Be marked for ID
8 purposes.
9 (Exhibit 766 marked for identification
10 only.)
11 MR. LISTON: Your Honor, at this time we
12 would like to offer the deposition or selected parts
13 of Judy Henry who is with the Methodist Hospital,
14 Methodist Hospital, Houston, Texas, and read those
15 portions that we've designated to the jury.
16 Mrs. Judy Henry was sworn by the court
17 reporter, and the following questions and answers
18 were given.
19 (Deposition of Judy Henry read into the
20 record.)
21 MR. LISTON: That's all we have, Your
22 Honor. We'd like to mark this deposition for
23 identification.
24 JUDGE CARLSON: All right. Be marked for
25 ID purposes.

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1 (Exhibit 767 marked for identification
2 only.)
3 MR. BELL: Your Honor, the Defendant next
4 calms Dr. Leslie Alpert by deposition.
5 (Deposition of Dr. Leslie Alpert read
6 into the record.)
7 MR. BELL: Your Honor, at this time, we'd
8 move to introduce Exhibits 2 and 3 to this
9 deposition, which are the medical records that
10 Dr. Alpert signed from Methodist Hospital, Houston,
11 Texas.
12 MR. MERKEL: No objection.
13 JUDGE CARLSON: All right. Be marked and
14 received into evidence.
15 MR. MERKEL: Your Honor, for the record,
16 I believe those are already included in P-1 as well,
17 so they'll be in the record two different places.
18 JUDGE CARLSON: All right.
19 (Continuation of the reading of
20 Dr. Alpert's deposition.)
21 MR. MERKEL: What page are you on,
22 please? Are you reading the whole deposition?
23 MR. BELL: Just designated parts.
24 MR. MERKEL: Your Honor, we haven't -- I
25 think we'd prefer, Your Honor, just to have the

2055
1 entire -- we'll counter designate whatever they're
2 leaving out. Because I thought that's what had been
3 designated. That's what our designation shows, the
4 entire deposition of Dr. Leslie Alpert.
5 MR. BELL: We made counter designations,
6 Your Honor, to what they offered, and they didn't
7 offer it in their case. So we've made counter
8 designations of her deposition.
9 JUDGE CARLSON: Am I understanding the

10 initial designation of the entire deposition?
11 MR. BELL: By the Plaintiff, not the
12 Defendant.
13 MR. MERKEL: No, Your Honor, by the
14 Defendant. "Defendant R. J. Reynolds may read the
15 entire deposition of Dr. Leslie Alpert."
16 JUDGE CARLSON: That's what it says.
17 MR. BELL: And Your Honor, we made
18 objections, we made some counter designations to the
19 testimony. So we're not reading all of it, just the
20 portions that -- to save time in interest of
21 economy. If there are other portions that the
22 Plaintiff wants, we'll be glad to the read those
23 now, or they can come behind us.
24 JUDGE CARLSON: As I understand what
25 Mr. Merkel that he would counter designate whatever
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1 --
2 MR. MERKEL: Whatever they left out, we'd
3 like the entire thing read for completeness. It
4 will save time to do it now rather than us trying to
5 coming back through and splice it later.
6 MR. BELL: The entire deposition?
7 MR. MERKEL: The entire deposition.
8 MR. BELL: We're back to page 24?
9 MR. MERKEL: I assume, Your Honor, we've
10 skipped a whole lot already. I've been trying to
11 follow and couldn't keep up with where he was, and
12 now I understand why.
13 JUDGE CARLSON: Start back at the very
14 beginning. Mr. Ulmer, start reading -- where did
15 you start?
16 MR. ULMER: Your Honor, we started on
17 page 6, but we have not read everything from 6 to
18 where we were on 24.
19 JUDGE CARLSON: You just need to start
20 back at the beginning maybe excluding any
21 preliminaries, but as far as the testimony, let's
22 just start at the beginning.
23 MR. BELL: I believe, substantively, Your
24 Honor, it starts on page 10 where we asked her what
25 she did to the prepare for the deposition. Is that
2057
1 acceptable?
2 MR. MERKEL: Well, I believe it begins on
3 page -- preliminaries are on page 5, and looks like
4 the first question begins on page 6.
5 MR. BELL: Your Honor, that's just
6 preliminary background. If they want it read, we'll
7 read it.
8 MR. MERKEL: We would like it all read,
9 Mr. Bell, yes, sir.
10 JUDGE CARLSON: All right.
11 MR. BELL: Page 6?
12 MR. MERKEL: Yes, sir.
13 (Deposition of Dr. Leslie Alpert read
14 into the record.)
15 MR. MERKEL: Your Honor, we just left out
16 again about seven lines of it.
17 MR. BELL: We've already read that.
18 JUDGE CARLSON: Let's just start back.
19 Let's get it going so we can go ahead and move on.
20 MR. ULMER: Tell me where to start. I'm

21 the witness, and you're the lawyer.
22 MR. BELL: We'll start at page 5.
23 (Continuation of the deposition of
24 Dr. Leslie Alpert read into the record.)
25 (Exhibit 768 marked for identification
2058
1 and entered into evidence.)
2 (Exhibit 769 marked for identification
3 and entered into evidence.)
4 JUDGE CARLSON: Excuse me. That might be
5 a good place to stop right there and let the jury
6 take a break. Ladies and gentlemen, we'll take a
7 short break and get you back in the box.
8 (A short break was taken.)
9 MR. BELL: Your Honor, here's another
10 copy of the deposition. This is where we are.
11 JUDGE CARLSON: I was trying to look over
12 Mike's shoulder to see. All right. Mr. Bell.
13 MR. BELL: Thank you, Your Honor.
14 (Continuation of the reading of the
15 deposition of Dr. Alpert.)
16 MR. BELL: Your Honor, we have the
17 deposition which can be marked.
18 JUDGE CARLSON: All right. It will be
19 marked for identification, marked for ID purposes.
20 (Exhibit 770 marked for identification.)
21 JUDGE CARLSON: Ladies and gentlemen,
22 let's go ahead and take a lunch break, and see you
23 back at 1:00 o'clock.
24 (A lunch break was taken.)
25 (Jury enters courtroom.)
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1 JUDGE CARLSON: All right. Ladies and
2 gentlemen, we are ready to go forward. Once again,
3 you've had the lunch break, and I need to ask of
4 you, if you've had occasion to talk to anyone,
5 anybody made an effort to talk to you or any outside
6 information you may have gained about the case,
7 anything you need to bring to my attention? Okay.
8 I take it, then, there have been no contacts or
9 discussion. Mr. Ulmer.
10 MR. ULMER: We call Dr. Eric Lang.
11 ERIC LAND, M.D.,
12 having been first duly sworn, was examined and
13 testified as follows:
14 DIRECT EXAMINATION BY MR. ULMER:
15 Q. Good afternoon, Dr. Lang.
16 A. Good afternoon, ladies and gentlemen.
17 Q. What is your name, please, sir?
18 A. Eric K. Lang.
19 Q. And are you a medical doctor?
20 A. I am.
21 Q. And what is your area of specialty,
22 please, Dr. Lang?
23 A. Radiology.
24 Q. And at this time, where and how are you
25 employed?
2060
1 A. I'm at LS -- at Tulane Medical Center,
2 New Orleans.
3 Q. At Tulane Medical Center in New Orleans?
4 A. Right.
5 Q. How long have you been there?

6 A. I have been full-time at Tulane for the
7 past two years. I have actually been on staff at
8 Tulane since 1976.

9 Q. Okay. Now, I know you're at Tulane. Are
10 you also at any other universities or hospitals?

11 A. Yes, I have professorial appointments at
12 SUNY, downstate New York, and at University of South
13 Alabama, Mobile.

14 Q. Are you a professor of radiology at
15 Tulane?

16 A. Yes, I am.

17 Q. And I detect the very slightest of
18 accents, Dr. Lang. Where were you born, please,
19 sir?

20 A. I was born in Vienna, Austria.

21 Q. Look over here and just tell the jury
22 what circumstances brought you to this country, how
23 old you were and why you came to this country.

24 A. I was 19, 1950, and I came over as a
25 fellow, on a fellowship program that was fully
2061

1 funded for one year to work at Columbia University,
2 a so-called Fulbright Fellowship.

3 Q. Tell the jury what Fulbright Fellowship
4 is.

5 A. Well, Fulbright Fellowship was originally
6 founded by the late Senator Fulbright from Arkansas.
7 And it was designated to bring scholars,
8 approximately 20 to 30 a year, into various learned
9 institutions in the United States for a one to the
10 three year tenure.

11 Q. The 20, 30, was that worldwide?

12 A. That was worldwide, yeah.

13 Q. Besides teaching radiology, are you
14 actively involved in patient care there at Tulane
15 University Hospital?

16 A. Yes, I am.

17 Q. Just, for instance, and without divulging
18 any patient privileges, how did you spend yesterday?

19 A. Well, basically, with interventional
20 procedures. Which are invasive procedures, vascular
21 system, catheterization of vascular system, biopsies,
22 drainage of abscesses. Yesterday, I happened to have
23 about three vascular procedures, and about four
24 biopsy and drainage procedures.

25 Q. All right. What is radiology?
2062

1 A. Radiology is really a composite for three
2 subareas, diagnostic radiology, therapeutic
3 radiology, dealing primarily with cancer therapy.
4 And nuclear medicine, which basically uses
5 radioactive materials either for diagnosis or for
6 therapy.

7 Q. Okay. What is your principal
8 subspecialty?

9 A. My basic subspecialty is interventional
10 vascular radiology and genitourinary radiology.

11 Q. Would you describe some of the tests that
12 are most commonly done by a radiologist such as
13 yourself?

14 A. In my particular instance, I would be
15 mostly involved with oncological material. This is
16 some sort of cancerous tumors and diagnoses, and in

17 treatment also with vascular entities such as
18 stenosis or vessels that we dilate with balloons or
19 put stints in. Drainage of abscesses, particularly,
20 of course, confirmation of diagnoses by biopsies of
21 various areas where we suspect tumors or infectious
22 disease or whatever.

23 Q. Some like me are not that schooled in
24 medicine, and we hear about radiologists. But tell
25 the jury whether or not the radiologist is the

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1 person with special skills in interpreting such
2 things as x-rays.

3 A. Well, basically the function of a
4 radiologist is to serve as a consultant to the other
5 physicians in our area of special expertise. And,
6 A, to establish a diagnosis, help them establish a
7 diagnosis, and guide them in the proper use of the
8 diagnostic procedures to achieve a diagnose as
9 rapidly as possible.

10 And B, obviously intervention and
11 treatment. Where we can directly treat a condition
12 by means of image-guided, that means we observe the
13 particular disease, the particular lesion on a
14 x-ray, and then we guide the intervention on basis
15 of this observation.

16 Q. Let me ask you, though, more pointedly,
17 do you read and interpret x-rays on a daily basis?

18 A. Yes, I do.

19 Q. All right. Do you read, and interpret
20 and consult with other physicians on such things as
21 CT scans on a daily basis?

22 A. Yes, I do.

23 Q. And have spent how many years doing that?

24 A. Well, CT scans since they came into
25 being, which is about 30 years.

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1 Q. And x-rays, how long?

2 A. X-rays for my entire career, which is
3 about 44 years.

4 Q. All right. Do you use such tools as MRIs
5 to help diagnose disease?

6 A. Likewise, MRIs. These, of course, have
7 only been in existence for practical purposes for
8 the past 15 years.

9 Q. All right. Do other doctors look at and
10 interpret CTs and x-rays, for instance?

11 A. Yes, they certainly look at them.

12 Q. Who has -- who has the special training
13 as between other physicians and a radiologist to
14 interpret what's shown on the film?

15 A. This is pretty well exclusively the main
16 of radiologists. And we serve as the principal
17 consultant to other physicians to help them
18 maximally utilize the information that we generate.

19 Q. Your primary concentration, I think
20 you've explained to the jury, is in interventional
21 and diagnostic radiology. What's involved in
22 interventional radiology? What is that?

23 A. Well, interventional radiology is the
24 subspecialty of radiology that is charged with
25 either treating a condition or helping to define a

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1 condition. For example, if you find a lump

2 somewhere, we can, for example, treat this lump by
3 invasive radiology.
4 We have needles that can be converted
5 into a high energy, basically cooking a tissue. For
6 example, a small cancerous lesion, we can cook by
7 this means. And to be certain that we're in the
8 right area, we use radiologic modalities to steer us
9 to it. So this is intervention radiology.

10 The other thing, obviously, that is done
11 is if you have an abnormal lesion, this could be an
12 abscess, or it could be an inflammatory lesion. We
13 guide a needle diagnostically into it. We aspirate
14 a sample, we culture the bugs. And then establish
15 on the basis of this information what the optimal
16 type of antibiotic would be to attack the process.
17 Or if it is a solid lesion that could be a cancer,
18 then we guide a needle into it to get an appropriate
19 sample for it, and establish what type of cancer it
20 is and, again, how best it could be treated.

21 Q. Okay. We -- the jury has heard in this
22 case that in November of 1988 that Joe Nunnally went
23 to the Methodist Hospital in Memphis with a mass in
24 his -- at least one mass in the right upper lobe,
25 and that there was a fine needle aspirant done. Is

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1 that or not the kind of procedure that you routinely
2 do?

3 A. Yes, this is a classical procedure that
4 we use.

5 Q. And the material that is removed on the
6 fine needle biopsy, what is that called?

7 A. It is cytopathologic and cytologic
8 material, the aspirant, and it is processed
9 cytopathologically.

10 Q. Would a lay person call that a biopsy?

11 A. Biopsy if you want to, yeah.

12 Q. Dr. Lang, I've got your resume here, and
13 it's 84 pages long. I obviously don't want to go
14 through your entire resume. But let's briefly let
15 the jury know what call qualifies you to be here to
16 give expert opinion in the field of radiology. Tell
17 us about your educational background and training,
18 please, sir.

19 A. I started medical school at University of
20 Vienna, Austria. I then went to Columbia
21 University, New York. I finished my medical degree
22 in 1953. I then took a research residency in
23 radiology at University of Vienna for one year.

24 I did my rotating internship at the
25 University of Iowa in Iowa city for one year,

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1 followed that with residency in internal medicine at
2 University of Iowa for one year then came to Johns
3 Hopkins Hospital for my residency in radiology for
4 three years.

5 After that, I stayed on staff at Hopkins
6 for some time.

7 Q. Is that John Hopkins in Baltimore,
8 Maryland?

9 A. Yeah.

10 Q. Are you board certified in the field of
11 radiology?

12 A. Yes, I am.

13 Q. When did you become board certified in
14 that field?
15 A. I'm sorry, sir.
16 Q. When did you become board certified?
17 A. In radiology in 1959, nuclear medicine
18 1973, and then we have a 10-year limited
19 certification that came into existence now, which I
20 have in vascular interventional radiology, 1996 to
21 2006.
22 Q. Are you an American citizen?
23 A. Yes, I am.
24 Q. When did you become an American citizen?
25 A. 1960.

2068
1 Q. Did you serve in the American military?
2 A. Yes, I did.
3 Q. When did you serve in the American
4 military?
5 A. 1961 to '64.
6 Q. Now, we've established that you're at
7 Tulane now. How did a fellow make it from Vienna to
8 John Hopkins in Baltimore down into Louisiana? Tell
9 the jury about that.
10 A. I had worked scientifically with a
11 cardiologist by the name of Dr. Edgar Hall, who was
12 appointed Dean for the medical school in Shreveport.
13 And he asked me to come down and head the department
14 as professor and chairman, director in Shreveport,
15 which is the second medical school at LSU. We have
16 one in New Orleans, and we have one in Shreveport.
17 So I served in Shreveport as director and
18 chairman for eight years. In 1976, myself and three
19 of my staff members were recruited to go down to New
20 Orleans because there were problems there in
21 staffing the department in New Orleans. So after
22 that, I served in New Orleans at the medical school
23 as professor and chairman.
24 Q. Now, when you say professor and chairman,
25 I know you teach as professor. But do you also take
2069
1 care of patients, and did you also take care of
2 patients during that time period?
3 A. Yes, I took care of patients, and I was
4 also director of the department, administrative
5 director.
6 Q. How many years, total, did you spend in
7 the LSU system?
8 A. Total with my sabbatical years, 28 as
9 chairman, 24-and-a-half.
10 Q. Up here in this part of the world, there
11 are a lot of different football fans, but I can tell
12 you none of them are LSU fans, I don't think,
13 although there may be an exception.
14 JUDGE CARLSON: I think you've got one.
15 MR. ULMER: We've got one.
16 Q. (By Mr. Ulmer) Are you a LSU fan?
17 A. I guess so. I -- are you referring to --
18 Q. To the LSU Tigers? Are you a Tiger fan?
19 A. That's a different story. I'm a great
20 tiger fan. That's the tiger, personal friend of
21 mine?
22 Q. How is the tiger a personal friend of
23 yours?

24 A. One of my patients.
25 Q. So -- tell the jury?
2070
1 A. About 10, 12 years ago --
2 Q. How owe you --
3 A. LSU has a pet tiger which was allowed on
4 the football field until I guess about 12, 15 years
5 ago when the local con stab Larry banned him from
6 further appearances in the open, but he was really a
7 very nice cat, except he got sick one time, and they
8 couldn't figure out what he had. So I finally got
9 recruited as a great expert to look at him.
10 I had never seen a tiger x-ray before in
11 my life, neither had the veterinary of ear
12 infection. But it turned out that the tiger had an
13 ear infection, which we did diagnose with x-rays,
14 and we treated it. And the tiger recovered, and you
15 know, his name was Mike the tiger. And I got a
16 Christmas card, Mike the tiger, and below it says, I
17 love you, Michelle. Because the original Mike had
18 died some time ago, and the replacement Mike was
19 really a female, but she was a very cute cat.
20 Q. So you're an expert on, what is that, ear
21 infections in tigers, you're not claiming --
22 A. Expert, I have seen one, treated one and
23 won one, so that's okay.
24 Q. Okay. All right. With that out of the
25 way now, we can get back, I guess, to more serious
2071
1 business. You've taught, I know, for a long time.
2 Do you teach not only medical students, but doctors
3 as well, Dr. Lang?
4 A. Yes, we do.
5 Q. Approximately how many students have come
6 under your direct supervision and have been taught
7 by you over the years in the field of radiology?
8 A. Medical students somewhere between three
9 and 5,000. Now, physicians, that means residents in
10 training for the specialty of radiology, somewhere
11 in the neighborhood of 140.
12 Q. Okay. This may be obvious, but have you
13 taught courses in the radiological diagnosis of --
14 of cancer and the treatment of cancer?
15 A. Yes, I have.
16 Q. For all areas of the body?
17 A. Predominantly for the genitourinary
18 tract, but also for all oncological involvements,
19 that is cancerous type of indications.
20 Q. You've already told the jury that
21 yesterday you spent your day in a hospital setting
22 doing diagnostic and therapeutic radiological
23 procedures on patients. Are you actively involved
24 at this time in the practice of radiological
25 medicine?
2072
1 A. Yes, I am.
2 Q. On a full-time basis?
3 A. Yes.
4 Q. Approximately -- tell me the approximate
5 number of abnormal abdominal and chest x-rays and
6 CTs that you would see on an average month?
7 A. About 4 to 500.
8 Q. All right, sir. Now, we've talked about

9 the fact that, as a radiologist, you're often asked
10 to consult with other physicians such as an internal
11 medicine doctor or a pulmonologist. Would those be
12 examples?

13 A. Yes.

14 Q. And when they come to you as a
15 radiologist, you know, what are they asking you when
16 they -- what do you see in this film and what does
17 it mean, those kind of questions?

18 A. Yes. They were first asked for an
19 opinion on the disease entity that we're looking at.
20 And for guidance and further investigating it. What
21 other examinations we would suggest, and how we
22 could further the diagnosis.

23 Q. Okay. And I think we've already
24 established that -- or let's establish, do you
25 routinely do biopsies of cancer and other materials

2073
1 that need to be removed from the body?

2 A. Yes, I do.

3 Q. And you routinely do such things as this
4 fine needle aspirant procedure that you talked
5 about?

6 A. Yes, I do.

7 Q. And do you or not do that with the help
8 of a CT scan?

9 A. Mostly, about 95 percent will be done
10 with a CT guidance, some of them may be done under
11 MRI guidance, magnetic resonance, some of them may
12 be done with ultrasound guidance. In the old days,
13 a lot of them were done with fluoroscopic guidance.

14 Q. Is the purpose of the CT guide to make
15 sure the needle is exactly in the tumor as opposed
16 to being somewhere else?

17 A. That's exactly the purpose. You confirm
18 the source where you get the biopsy from. This is
19 important. If you get a negative biopsy, you
20 wouldn't have documentation where you get the
21 material from, it would be meaningless.

22 If you get a negative biopsy and you know
23 you were in the middle of the lesion, you know this
24 is not a neoplasm.

25 Q. One of the things that I think we've done
2074

1 a poor job of is that we use the word tumor, and
2 lesion and other such words kind of interchangeably.
3 Should they be used interchangeably or not,
4 Dr. Lang?

5 A. We use the term "lesion" for anything
6 that we have not defined further. We then proceed
7 to classify it after we know whether it's an
8 infectious lesion or whether it is a neoplastic
9 lesion or cancer. But lesion is the comprehensive
10 overall term.

11 MR. MERKEL: Excuse me, Your Honor, I
12 don't know if we're still qualifying the witness,
13 whether he's been tendered or whether we're into
14 some opinion testimony. So --

15 MR. ULMER: I'm still qualifying, Your
16 Honor. I'll tender him in a minute.

17 MR. MERKEL: All right. That seemed more
18 like opinion testimony than qualification.

19 Q. (By Mr. Ulmer) In absence of an autopsy

20 or surgery, how do you determine the location of a
21 lesion?

22 A. By biopsy.

23 Q. Guided CT biopsy?

24 A. Guided CT biopsy, yes.

25 Q. Is there any clinical way to determine

2075

1 the location of a lesion within the body more
2 accurately than through radiological procedures that
3 you perform?

4 A. With exception of endoscopic definition.
5 For example, if you have a lesion in the stomach,
6 you could put a gastroscope down and identify it
7 with such. So if you can reach it with a scope that
8 has an optical type of scope to it, then it would be the
9 most optimum modality.

10 Q. Does the location and the appearance of
11 the lesion help you determine an appropriate
12 diagnosis?

13 A. Yes, it does.

14 Q. Is that important information?

15 A. It's extremely important.

16 Q. Now, Dr. Lang, in looking through your
17 resume, I see that you are a member of the American
18 College of Chest Physicians. Are radiologists
19 normally invited to participate in the American
20 College of Chest Physicians?

21 A. Normally not, but I got into it because I
22 have a special interest and developed pulmonary
23 angiography at that time which is heavily used in

2076

1 that field. And, therefore, was invited as a fellow
2 into this organization.

3 Q. Was that the first such procedure ever
4 performed in this country?

5 A. No.

6 Q. Now --

7 MR. ULMER: Now, I'm going to lead a
8 little bit, Your Honor, to get through the
9 qualifications with the Court's permission.

10 Q. (By Mr. Ulmer) You have lectured
11 extensively at most major institutions in the United
12 States, have you not?

13 A. I have.

14 Q. And you've lectured in foreign countries?

15 A. I have.

16 Q. And have you lectured on things such as
17 cancer treatment procedures?

18 A. Yes, I have.

19 Q. Many times?

20 A. Many times.

21 Q. And are you involved in any research at
22 this time?

23 A. Yes, we're basically involved in primary
24 research on genitourinary tumors. We're involved in
25 the research efforts on biopsy and safe biopsy

2077

1 procedures of this nature.

2 Q. Do you have anything going with the
3 National Institute of Health?

4 A. Yes, I do.

5 Q. What is that?
6 A. We have asked for a grant to utilize CT
7 in the detection of abnormalities in the chest of
8 very fine cuts, very thin cuts, one millimeter or
9 less.
10 Q. In look through your 84-page resume, I
11 see you're a member of 24 different medical
12 societies, and rather than go through them all, let
13 me just give the jury just a sample and tell me if
14 you're a member of that society, the Radiological
15 Society of North America?
16 A. Yes.
17 Q. The American College of Radiology?
18 A. Yes.
19 Q. The Society of Uroradiology?
20 A. Yes.
21 Q. The Society of Nuclear Medicine?
22 A. Yes.
23 Q. The American Neurologic Association?
24 A. Yes.
25 Q. The American College of Chest Physicians?
2078
1 A. Yes.
2 Q. The Society of Cardiovascular and
3 Interventional Radiology?
4 A. Yes.
5 Q. And the American Fertility Society?
6 A. Yes.
7 Q. Now, tell this jury how many journal
8 articles, and books and chapters of books that you
9 have written.
10 A. Approximately 350 journal articles, and
11 approximately 70 books or chapters in books.
12 Q. Did you write anything for the July issue
13 of "Radiology"?
14 A. This year?
15 Q. Yes, sir.
16 A. Yes.
17 Q. What was the name of that article?
18 A. This was a technique, patch technique for
19 facilitating biopsy of lung lesions and avoiding
20 pneumothorax. It's in this weeks publication of
21 "Radiology".
22 Q. Are any of your articles peer reviewed?
23 A. Yes, the majority.
24 Q. And just tell the jury what it means to
25 put your article in a journal that is peer reviewed?
2079
1 A. "Peer reviewed" simply means that at
2 least two editors evaluate an article before they
3 determine where it should be published or not.
4 Nonpeer reviewed, you simply submit it and most of
5 these articles may be published. Peer reviewed, you
6 have at least two experts looking at it before they
7 decide whether it is for publication.
8 Q. Are you a peer reviewer?
9 A. Yes, I am.
10 Q. And are you on any editorial boards?
11 A. Yes, I am.
12 Q. Now, have you ever testified in Court
13 before?
14 A. Yes.
15 Q. How many times?

16 A. Twice.
17 Q. Have you ever testified in a case
18 involving tobacco?
19 A. One, yes.
20 Q. One time. And where was that?
21 A. It --
22 Q. What state?
23 A. Louisiana.
24 Q. All right. Now, what do you charge for
25 interpreting CTs and x-rays in your hospital setting
2080
1 everyday?
2 A. Well, you have a charge system that is
3 developed by our business office which is basically
4 based on a rate of \$400 per hour of time commitment.
5 Q. What are you charging in this case to
6 prepare to give testimony in it?
7 A. The same.
8 Q. Now, let's provide the jury with just a
9 little bit of background on x-rays and CTs before we
10 get to -- get to Joe Nunnally and his case. And
11 just tell the jury, briefly, what a x-ray is and how
12 it's done.
13 MR. MERKEL: Your Honor, are we tendering
14 him yet in?
15 MR. ULMER: I still haven't tendered him,
16 Your Honor.
17 MR. MERKEL: Well, then, I object to
18 asking him opinions until he's been qualified by the
19 Court, Your Honor.
20 JUDGE CARLSON: Let's get through the
21 qualification, and have him tendered for voir dire.
22 Q. (By Mr. Ulmer) All right, sir. Just
23 briefly, what is a x-ray, how is it done?
24 A. A x-ray beam is generated. It is sent
25 through the patient, and a photographic plate is
2081
1 behind the patient and records what is going
2 through. So basically the through-coming radiation
3 generates the picture.
4 Q. All right. Is the x-ray the important
5 diagnostic tool in diagnosing lung cancer?
6 A. Yes, it is.
7 Q. What about the CT? How does it differ
8 from a x-ray?
9 A. The CT is the principal examination with
10 high fidelity and high value of diagnosis. It is
11 also a x-ray beam that is sent through the patient.
12 But rather than to put on a photographic plate, it
13 is then received by monitors, and in then the
14 monitors process it digitally to make an image. So
15 it is a digital reproduction of what is going
16 through rather than a direct picture.
17 Q. Now, are CTs more accurate than x-rays?
18 A. Yes, they are.
19 Q. In reaching your opinions in this case,
20 have you looked at all the available x-rays and CTs
21 with respect to Joe Nunnally?
22 A. I have.
23 Q. All right, sir. Now, do lung tumors have
24 certain signature characteristics? And by that I'm
25 talking about size, shape, density, direction of
2082

1 growth and those kind of things that enable you --
2 MR. MERKEL: And again, Your Honor, we
3 object until he's qualified. I mean, these are
4 opinions that certainly can be given later but not
5 at this point.
6 JUDGE CARLSON: Have you gotten to
7 tendering him?
8 MR. MERKEL: We object to that question
9 that he's asking, Your Honor, because it is an
10 opinion.
11 JUDGE CARLSON: Let's go ahead -- I mean,
12 I think we're pretty well to the point of having him
13 qualified to the extent of having voir dire and
14 tendered for voir dire.
15 MR. ULMER: Your Honor, we offer Dr. Lang
16 at this time as an expert in radiology and
17 radiological diagnosis of lung cancer and diseases
18 of the chest.
19 JUDGE CARLSON: All right. Voir dire?
20 MR. MERKEL: Just a few questions, Your
21 Honor, very briefly.
22 VOIR DIRE EXAMINATION BY MR. MERKEL:
23 Q. Good afternoon, Dr. Lang.
24 A. Yes, sir.
25 Q. You told Mr. Ulmer a moment ago that you
2083
1 had, I think you said, only been involved in one
2 other tobacco case before; was that right, sir?
3 A. Testifying, yes, sir.
4 Q. Testifying. Okay. How many times have
5 you been involved on behalf of a tobacco defendant,
6 either in reviewing a chart, giving a deposition,
7 testifying, whatever the case may be?
8 A. About five or six times.
9 Q. All right. And I have some of those
10 depositions, so that's what I'm going to be
11 referring to and try to move through this in a
12 hurry, Dr. Lang, I'm sorry. As I understood what
13 you said, your specialties are in vascular
14 radiology, and genitourinary type radiology?
15 A. Genitourinary and oncological radiology,
16 which is cancer radiology diagnosis.
17 Q. Radiation of tumors to try to irradiate
18 them with radiation?
19 A. Well, I'm trained in that. But
20 basically, it is chemotherapy, for example, where
21 you introduce catheters into the supply vessel of
22 the tumor and provide chemotherapy,
23 chemoabulization, where you put small particles of
24 chemotherapeutic agents into the tumor,
25 sensitization for external radiation therapy with
2084
1 chemotherapeutic agents, and also --
2 JUDGE CARLSON: I think you can move back
3 a little bit from the mic.
4 A. Or broncotherapy which is the
5 introduction of radioactive material through
6 catheters into the vascular supply of tumors.
7 Q. (By Mr. Merkel) As far as diagnostic
8 radiology, Dr. Lang, how much of your practice would
9 be devoted to the genito tract or the urinary track
10 area as opposed to the chest?
11 A. Well, that's hard to answer, because in

12 many instances, genitourinary tumors metastasize to
13 the chest. So practically with every genitourinary
14 tumor, we get chest films, and we get chest CTs.
15 Because this is a common way of having
16 metastasizes, and this is a primary thing we have to
17 evaluate.

18 Q. So there are two different x-rays that
19 are involved?

20 A. That is correct.

21 Q. One is a chest x-ray, and one would be a
22 stomach film of the lower?

23 A. Precisely.

24 Q. But you check both areas, regardless of
25 where you think the thing --

2085

1 A. Absolutely.

2 Q. -- began?

3 A. Absolutely.

4 Q. Now, of your total time, Doctor, you're a
5 teacher now, correct?

6 A. Yes.

7 Q. And of your weekly time, monthly, however
8 you want to break it down, annually. What
9 percentage of your time would be devoted to actual
10 patient care, what percentage to teaching, or
11 laboratory type medicine, and what percentage to
12 this type stuff, this medical legal work?

13 A. Approximately two-thirds of my time is
14 devoted to patient care, often I will be accompanied
15 by physicians in training. Most of the time, they
16 will be with me in direct care, but I will execute
17 the patient care as the primary physician.

18 Approximately 10 percent to pure
19 teaching. That means sitting in an auditorium and
20 lecturing. And practically all of the remainder of
21 the time to primary research work in the laboratory
22 or otherwise.

23 As far as your question is concerned, my
24 involvement with testifying, it is infinitesimal. I
25 have looked at about six cases of this nature. I

2086

1 have been subpoenaed as -- in Louisiana, we have a
2 system on malpractice cases where a panel of three
3 physicians has to arbitrate cases. I have seen
4 probably about 10 of these cases where the Court
5 requires our services.

6 So the sum total time commitment of that
7 is extremely small, less than one percent of my
8 total time.

9 Q. Okay. And as far as this case is
10 concerned at \$400 an hour, Doctor, what time do you
11 have involved in this case up to now?

12 A. In this case, I would say quite a bit,
13 probably 20 hours, maybe even 25 hours.

14 Q. And that was before you traveled from New
15 Orleans here?

16 A. No, that's --

17 Q. That's up to right now?

18 A. That's the time, yeah, that I have
19 involved in it.

20 Q. So by the time you get back to New
21 Orleans, whenever that is, 25 hours or so?

22 A. I don't know. That depends on how good

23 the connection in Atlanta is. I don't -- I don't
24 charge for travel.

25 Q. If you left right now, you'd be another
2087

1 five hours getting home?

2 A. It would be three-and-a-half hours over
3 to Atlanta, that is right.

4 Q. That would be the best connection you
5 could have?

6 A. That is true.

7 Q. And about \$10,000 on this particular case
8 would be a ballpark figure?

9 A. It may -- may be about like that, yeah,
10 8,000, 10,000, I don't know exactly, somewhere in
11 that line.

12 Q. And I believe based on your testimony in
13 some other cases, Dr. Lang, you do not, in the part
14 of your practice where you're making diagnoses, you
15 do not make any attempt to determine what the cause
16 of a tumor was --

17 A. Oh, yes.

18 Q. -- in other words, whether it was
19 cigarette smoking or whether it was something else?

20 A. No.

21 Q. You make no attempt to correlate those
22 two statistically or otherwise?

23 A. Yes, we do. For example, we have an
24 investigative series going on on bladder carcinoma
25 where we correlate it very closely to cigarette
2088

1 smoking. And we correlate it very closely to
2 aniline dyes.

3 Q. Let me ask you if you remember, Doctor,
4 testifying in Circuit Court in Duval County, Florida
5 in the case of "John Keggen versus R. J. Reynolds"?

6 A. Yeah.

7 Q. You were asked that question at that
8 time, but you made no conclusion of whether it was
9 caused by cigarette smoking, and you said
10 statistically, no, I don't correlate it.

11 A. That wasn't bladder cancer.

12 Q. No, I'm talking about lung cancer?

13 A. No, I'm talking about bladder cancer.

14 Q. Oh, okay.

15 A. I said we have a specific protocol where
16 we're correlating the occurrence of cancer,
17 carcinoma, to cigarette smoking --

18 Q. In the bladder?

19 A. -- in bladder cancers, and the use of
20 aniline dye in bladder cancers.

21 Q. But you've never made any such studies or
22 correlations with regard to lung cancer?

23 A. No, sir.

24 Q. And you are not an epidemiologist of any
25 sort?
2089

1 A. No, sir.

2 Q. Nor a pathologist?

3 A. No, sir.

4 Q. And in the way the system works, you're
5 sort of the first line of discovery. You, by
6 picture, either x-ray, or CT or MRI or whatever, you
7 discover what appears, at least by image, to be a

8 lesion of some sort in some part of the anatomy?

9 A. Yes.

10 Q. And then you refer that over to a
11 pathologist who, in some form, takes an aspirate or
12 a specimen one way or the other, a biopsy, if you
13 will, or something of that nature. And then they
14 tell us what the actual lesion is, what it is made
15 of?

16 A. No, that wasn't precisely describe it.
17 Basically what we do is we may discover the lesion.
18 The average patient in the United States today has
19 at least 2.4 x-rays per patient. So this is a very
20 heavily used modality. We discover the lesion.
21 Then we will advise the physician and patient as to
22 our ability to further amplify the diagnosis by
23 additional tests. Very frequently, this would be,
24 for example, MRI or ultrasound tests of the same
25 area to further define the lesion and to come up

2090

1 with as close as possible a high probability
2 diagnosis.

3 Now, lastly, we would then, again, with
4 consensus of the other physicians involved in it,
5 proceed in many instances to a biopsy to provide
6 histopathologic material for a diagnosis, or to
7 provide material for doing a culture and
8 establishing a bug or whatever it is. And establish
9 the type of antibiotic that you need to treat it.

10 Q. And then the primary physician in
11 whatever specialty he may be takes your reports, the
12 pathology reports, and he, then, determines a course
13 of treatment with more consultation, if he needs it,
14 and he then directs the treatment?

15 A. Well, again, we will work in concert with
16 the pathologist. For example, there are some
17 tumors, specifically bone tumors, that are literally
18 not diagnoseable pathologically. But they are
19 diagnoseable radiologically, and you have a combined
20 diagnosis.

21 Likewise, in other areas, we can provide
22 a probability diagnosis in the range of 98 percent,
23 in many instances on basis of the appearance of the
24 lesion and a number of other characteristics. So
25 the final diagnosis is expressed as a concert of

2091

1 opinions between the pathologic data, the radiologic
2 data, and, frequently, biochemical data that reveal
3 the presence of a tumor. That may be on blood
4 samples, urine samples, whatever have you.

5 Q. So to kind of sum that up, the final
6 diagnosis and the plan for treatment is arrived at
7 by the primary physician in charge of the case with
8 whatever help he needs from radiology and pathology,
9 all the way through.

10 A. Well --

11 Q. In other words, if it's a difficult
12 thing, than it requires more assistance of yours
13 than the first report, then that guy will get your
14 assistance all the way to the end when he finally
15 reaches a final diagnosis?

16 A. I would say in our particular area, this
17 is not the way it is. We have a tumor board, for
18 example, at which we have all specialties,

19 subspecialties represented. And it has to be a
20 composite opinion. It is never the opinion of one
21 person. In fact, we record the data of the findings
22 of the tumor board, each case has to be presented.
23 There has to be a radiologist, there's usually a
24 radiation oncologist there. There's a
25 chemotherapist there. There's mandatorily a surgery
2092

1 surgeon there.

2 May be the primary referring physician
3 there, pathologist, composite of at least six people
4 who arrive at the treatment recommendation. And
5 then the patient, of course, finally decides whether
6 he accepts the treatment recommendation or not.

7 Q. So the composite diagnosis and treatment
8 plan, then, has input from everybody involved,
9 including whoever is sitting in your position as the
10 initial radiologist?

11 A. Yes, sir.

12 Q. And whatever they come up with in the end
13 includes your counterparts' contribution to whatever
14 extent is needed or supplied?

15 A. Yes, sir.

16 MR. MERKEL: Okay. That's all we have on
17 voir dire, Your Honor.

18 JUDGE CARLSON: The Court will declare
19 Dr. Lang is an expert in the field he's so offered.
20 CONTINUATION OF DIRECT EXAMINATION BY MR. ULMER:

21 Q. Dr. Lang, before you were voir dired by
22 Ms. Nunnally's attorney, I was asking about tumors
23 in the lung, if their size and their shape and if
24 their appearance help you make a diagnosis as to
25 what type of cancer that is. Is that so or not?

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1 A. Yes, that is definitely so.

2 Q. Do squamous cell tumors, do they have
3 certain radiological characteristics that are
4 distinct or different from sarcomas or lymphomas or
5 other things of that nature?

6 A. Yes, they do.

7 Q. When you look at a x-ray or CT scan, can
8 you make a radiological judgment as to whether a
9 tumor is a squamous cell carcinoma or a sarcoma?

10 A. Yes, we can, with a very high degree of
11 probability and accuracy.

12 Q. What -- just a little more background
13 before we look at the time Mr. Nunnally's x-rays,
14 just so we're on the same page. What is
15 bronchogenic cancer?

16 A. Bronchogenic cancer is a cancer that
17 develops from the epithelium surface of the bronchi.

18 Q. And what is carcinoma?

19 A. Carcinoma is simply a cancer from
20 anywhere. Carcinoma can be from anywhere.

21 Q. And we've talked about squamous cell
22 carcinoma?

23 A. Squamous cell, certainly is one that
24 occurs in the lung. Squamous cell carcinoma also
25 occurs in the skin. The most common squamous cell
2094

1 carcinoma would be one of the skin.

2 Q. Is the squamous cell tumor in the lung
3 associated or not with cigarette smoking?

4 A. Yes, it is.
5 Q. Tell the jury what a sarcoma is.
6 A. A sarcoma is a interstitial type of tumor
7 that comes from the interstia, the cells in between.
8 Such as, for example, cartilage or binding cells
9 between the superficial cells. And is likewise a
10 malignant tumor, but distinctly different from the
11 carcinomas that are from surface epithelium, from
12 surface areas.

13 Q. Are sarcomas connected with or associated
14 with cigarette smoking?

15 A. No.

16 MR. MERKEL: Your Honor, we object to
17 opinions about what's connected to cigarette
18 smoking. He's not been tendered as an expert in
19 that area. He has no background in it. Says he
20 doesn't even try to correlate cause of the lung
21 cancer to smoking.

22 JUDGE CARLSON: Based on the over all
23 record, I'll overrule the objection.

24 Q. (By Mr. Ulmer) Now, were you asked by
25 -- by me and by R. J. Reynolds to review all the

2095
1 radiological evidence that was available and provide
2 an opinion regarding Mr. Nunnally's disease process
3 from a radiological point of view only? Were you
4 asked to do that?

5 A. Well, I was asked by you attorneys. I've
6 never met anybody from R. J. Reynolds company.

7 Q. Did the attorneys ask you to do that?

8 A. Yes, the attorneys did asked me to do
9 that.

10 Q. And have you done that?

11 A. Yes, I have.

12 Q. Have you reviewed all the available
13 x-rays on Joe Nunnally?

14 A. All that were made available to me.

15 Q. And all the -- all the CTs that were made
16 available to you, you've reviewed those?

17 A. All that were made available to me.

18 Q. Have you reviewed Joe Nunnally's medical
19 records?

20 A. Yes, I have.

21 Q. Have you reviewed the deposition of
22 Dr. Alpert?

23 A. Yes, I have.

24 Q. And Dr. Alpert is the physician in
25 Houston, Texas, that was what kind of specialist,

2096
1 Dr. Lang?

2 A. She's a pathologist.

3 Q. All right. Now, did you review the
4 deposition of Dr. Routt, the radiologist in Memphis?

5 A. Yes, I did.

6 Q. If you were asked in a hospital setting
7 to give a second opinion in your area of expertise,
8 radiology, would you rely simply on the report of
9 the other radiologists, or would you insist on
10 seeing the actual films?

11 A. No, I would have to see the actual films.

12 Q. All right. If Dr. Burns testified that
13 he did not look at the actual radiology, the films,
14 and he did not look at the slides --

15 MR. MERKEL: Objection, Your Honor,
16 trying to pit one expert's testimony against
17 another. I don't think that's proper. He can ask a
18 question of the witness's opinion but not couched in
19 terms of what somebody else may say.

20 JUDGE CARLSON: Again, I'll overrule the
21 objection.

22 Q. (By Mr. Ulmer) Let me back up, Dr. Lang.

23 A. Yeah.

24 Q. Okay. If Dr. Burns testified that he did
25 not look at the actual films, and he did not look at
2097

1 the actual pathology, the slide material, the tissue
2 material, but he simply relied for his second
3 opinion or his import opinion on the reports of
4 others, would that or not violate the standard of
5 medical care at your hospital?

6 A. We, basically, as radiologists, are
7 compelled to look at the original films and
8 certainly also at the reports that are generated,
9 but the basis for second opinion should be the
10 original films.

11 Q. Now, I'm going to ask you a number of
12 opinion questions over the next probably 30 minutes,
13 Dr. Lang, and I want you to build into all of my
14 questions the requirement that any answers you give
15 be based on a reasonable degree of medical
16 certainty. Will you do that for me?

17 A. Yes.

18 Q. And have you prepared or had prepared at
19 your direction certain exhibits and illustrations
20 that would be helpful in explaining your testimony
21 to the jury?

22 A. Yes, I have.

23 MR. ULMER: I would like, with the
24 Court's permission, for Dr. Lang to be permitted to
25 step down.

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1 JUDGE CARLSON: Doctor, you can step
2 down.

3 MR. ULMER: If he could.

4 THE WITNESS: With your permission, Your
5 Honor.

6 MR. ULMER: A set of exhibits for the
7 Court.

8 THE WITNESS: With your permission, Your
9 Honor, these are first introductory drawings that
10 illustrate the use of x-rays on CT if, I may present
11 these first.

12 JUDGE CARLSON: All right.

13 A. This is a schematic drawing of the human
14 lung. You can see the trachea, wind pipe coming
15 down here. And then it divides into two main
16 sections. These are the main stem bronchi that now
17 go to the lung. Now, these divide in the lung and
18 supply the air to go to the lung for exchange for
19 oxygen.

20 Now, we have three distinct lobes on the
21 right side in the right lung. We have two lobes on
22 the left side. Importantly is that there are
23 different zones in the lung. The central zone of
24 the lung is approximately two inches around the area
25 where the bronchi come in, which we call the

2099

1 "hilar." And the peripheral zone of the lung is all
2 the rest of it, which is, again, about
3 two-and-a-half inches deep. This is, to some
4 degree, important because the central zone is
5 accessible to a technique that is called
6 "bronchoscopy."

7 We can stick a tube down and have an
8 optic and can directly look at lesions. Whereas in
9 the periphery, this is not accessible to the direct
10 visualization, so we rely entirely on x-rays or CTs
11 to identify lesions there and/or biopsy lesions.

12 Q. (By Mr. Ulmer) Let me ask a question,
13 please. Leave that up for just a minute, Dr. Lang.
14 In Joe Nunnally's case, was his -- well, tell the
15 jury about the tumors that were found, where they
16 were located.

17 A. In Mr. Nunnally's case, there were three
18 tumors identified in the lung. By far the largest
19 tumor was the tumor peripherally in the right upper
20 lobe in the back and to the very periphery of the
21 right upper lobe. Then there was a second, much
22 smaller tumor, which was also in the right upper
23 lobe that was immediately in front of it.

24 And the third smaller tumor was located
25 in the right middle lobe about an inch and a quarter

2100

1 size tumor in the right middle lobe also in front,
2 and I will show you that, then, on the obliques a
3 little better the location.

4 Q. With respect to the large tumor that was
5 in the right upper lobe, what was its approximate
6 size?

7 A. It was approximately 15 by 8 by 12
8 centimeters, a centimeter being two-and-a-half
9 centimeters to an inch is about six inch to five
10 inch, a very large tumor.

11 Q. And you said there was a smaller tumor
12 also in the right upper lobe?

13 A. Immediately in front of that is a smaller
14 tumor that is just a little less than an inch.

15 Q. And finally there was a tumor in the
16 middle lobe?

17 A. In the middle lobe, there is a third
18 tumor that was approximately an inch and a third.

19 Q. Okay. Is the location of the 15
20 centimeter mass in the right upper lobe, was it
21 central or peripheral?

22 A. It was extremely peripheral.

23 Q. And is that of significance?

24 A. Yes, it is.

25 Q. All right, stir. When you see a cancer

2101

1 that's related to smoking, where is it most often
2 found?

3 A. Most likely, it's originating from the
4 central bronchial areas. And it's a central tumor,
5 originates from the epithelium of the central
6 bronchi most often.

7 Q. In looking at this diagram which is
8 number, I believe, 471, when smoke comes down the
9 wind pipe or air, where does it go? Where does it
10 enter the lung? Smoke or air, when it enters the

11 wind pipe, where does it go into the lung?
12 A. Well, it will go along the bronchi into
13 the lung. It will then develop, go out into the air
14 sacks.
15 Q. Are you ready for the next board --
16 A. Yeah.
17 Q. -- to help illustrate your testimony?
18 A. Yeah.
19 Q. Stay right there. I'll get it for you.
20 A. Okay.
21 Q. Stay there. I'll help you. Let's put up
22 what's been marked as Awn-000472, and just tell the
23 jury what is being illustrated here.
24 A. This will help you to understand the
25 location a little bit better. It is slightly

2102

1 oblique. The patient here is turned slightly like
2 that, okay.
3 Now, on this you can see against the
4 right upper lobe, and you can see that the tumor in
5 Mr. Nunnally's case was located way to the back and
6 peripherally, in this general area. The second,
7 smaller tumor, was further in front, in this area
8 here. And the third smaller tumor that we were
9 talking about was located in the middle lobe. Again
10 relatively and materially, all of them in the
11 periphery of the lung.

12 Q. All right, sir. Let's put up number 473,
13 and let's tell the jury what we're looking at in
14 473, first, is this x-ray that's been superimposed
15 on 473, is that an actual x-ray of Joe Nunnally?

16 A. This is an actual x-ray of Joe Nunnally
17 that was selected. And this the x-ray relates on
18 the x-ray -- I'm sorry. Relates on the x-ray -- I'm
19 standing in front of you --

20 Q. Let's move?

21 A. Relates on the x-ray the location of the
22 upper lobe, and you can see it's all the way to the
23 periphery here, right, the white thing. The white
24 thing is a tumor. Just as a brief explanation, the
25 dense white stripes that you see here are the bones

2103

1 of the thoracic cage. They contain calcium and,
2 therefore, don't let the x-rays through so they
3 present as a white stripe.

4 The black areas is the aerated lung,
5 because that's air, and, therefore, the x-rays pass
6 through it, and it projects black. The heart is
7 relatively dense and absorbs the energy. Therefore,
8 it is relatively white and here is the diagram or
9 the liver below, again, it's dense, so it's dense.

10 If you have a tumor in the lung and no
11 more air in the lung, therefore, it presents white,
12 because it absorbs it. So you can nicely see here
13 the delineation of the tumor sitting up here, which
14 in relationship to our drawing is in the very
15 periphery of the upper lobe on the right side,
16 sitting in here.

17 And this is the same projection, so we
18 tried to show you on the patient where it would be,
19 and how it projects on the x-ray.

20 Q. All right. Let's look at this next
21 exhibit which would be 474 and tell the jury what

22 we're seeing again here, and is this from the
23 Methodist Hospital South, Joe Nunnally, November 21,
24 1988, CT?

25 A. This is what we call a CT scout film.

2104

1 It's again a plain chest radiograph, and you can see
2 these white stripes going across it. Now, these are
3 the indications of how we reconstruct the
4 information that we have. We try to look at it
5 instead of this way, we try to look at it from top
6 on a slab that is that thick. So theoretically what
7 we do is, we cut the patients in little pieces all
8 the way down, and we look at each one of the pieces
9 in a slice-like fashion. That gives us the
10 opportunity to look at a relatively thin section of
11 tissue and see what it looks like.

12 And we number these so we can correlate
13 them to the tables that we print out. The images
14 that come out of the CAT scan, so-called CT or CAT
15 scan are always in a horizontal plane oriented.
16 Whereas this one, the chest x-ray, of course, is an
17 upright vertical plane oriented.

18 Q. And again, before you remove it, is
19 the -- what's the thickness of the slices or the
20 cuts that we're making here on this particular film?

21 A. This one happens to be one centimeter
22 thick slices, approximately one-third to one-half
23 inch in thickness. They're about that thick, the
24 slices (indicating).

25 Q. Is the setting of the slices on the CT

2105

1 important or unimportant?

2 A. Yes, it's very important, and of course,
3 the most modern techniques take extremely thin
4 slices of less than one millimeter. So we have a
5 very high resolution, but one centimeter slices will
6 suffice for many particular informations that can be
7 derived from it, can be done.

8 Q. Before we go, over here, if I -- this is
9 the left side here, and this is the right side here.

10 A. This is the left side, this is the right
11 side.

12 Q. We see black in here indicating that
13 there is or is not tumor present on the left side?

14 A. As I say, a lung that contains air,
15 offers no resistance to the x-ray; therefore, it is
16 black. So wherever you have aerated lung, you have
17 black, like here and here. If you have soft tissue,
18 it absorbs the energy. And, therefore, it presents
19 white. The denser the tissue it is, so the whiter
20 it is. So ribs are very dense, so they cast a very
21 dense white stripe. A tumor is relatively dense.
22 It has a relatively white appearance.

23 Q. Go ahead and tell the jury what we're
24 looking at on 475, and make sure everybody can see.

25 A. Now, this is an appropriate slide that we

2106

1 have taken through about this level here.

2 You can see we have -- I'm bringing the
3 slice level through that here, and I'm documenting
4 to you the various areas, the tumor area, which is
5 in the right upper lobe in the back.

6 Q. Is that shown in green?

7 A. Green. The small purple one is the small
8 tumor that is in front of it.

9 Q. In the right upper lobe?

10 A. In the right upper lobe. The area that
11 you see here are on large vessels, the mediastinum,
12 and now we are looking at the thing from the top.

13 Q. And this is actually on Joe Nunnally, is
14 it not?

15 A. This is the actual slide derived from the
16 patient. You can see here again the very dense
17 white areas that you see here.

18 Q. What is that?

19 A. Are the ribs.

20 Q. You can see a very dense white area here,
21 extremely dense, that's the vertebral body, cutting
22 through the back of the vertebral body here. Then
23 you see an area that is all black, and that is air
24 rated lung. That's the aerated lung on the left
25 side. Then you see some black here which is aerated

2107

1 lung on the right side. And then you see the mass,
2 and you can see the mass goes all the way to the
3 ribs, so it's in the periphery. It's way, way out
4 in the lung. It is very large.

5 It is homogeneously dense, doesn't have
6 any holes in it, doesn't have any density
7 differences in it. It's homogeneously dense, and
8 there's a little bit of aerated lung in this area
9 here. Which means right in here, which means the
10 mass is not extended completely to the mediastinum.
11 And then here we have the so-called mediastinum
12 structures which happens to be the order at this
13 particular level.

14 Q. All right. Let's put this one aside,
15 let's look at 476.

16 A. 476 is just a little bit lower, and we
17 are cutting through more or less the same area here.
18 And you can see here the slice level, and this is
19 then indicated on the reference slice. We can read
20 off where the reference slice is so we know exactly
21 at what level we have cut it.

22 And on this particular one, you can again
23 see the dense white areas. Those are the ribs. You
24 see the intensely black area here which is aerated
25 left lung. You see intensely black area down here

2108

1 which is the remainder of the area of the right
2 lung. And then we have, again, this very large,
3 more or less homogeneously dense mass, which comes
4 all the way from the periphery, all this way from
5 the thoracic cage toward the bones, toward medially
6 and fills this entire space.

7 A little bit in front of that, you'll see
8 another one, looks like a little donut. A little
9 donut lesion, it's much smaller. It has a dense rim
10 and sort of a black center in it. And once again,
11 you can see that in the middle here toward the
12 mediastinum, you have again aerated lung, and then
13 you have mediastinal structures.

14 Q. All right, sir. Now, I want to put up a
15 x-ray film for Joe Nunnally that was dated in
16 7/1/85. It says Joe Nunnally; does it not?

17 A. This is Mr. Nunnally's film, and it's

18 dated July 1, 1985. It's a plain radiograph, and
19 basically relatively unremarkable. You can see that
20 both lungs are more or less homogeneously black.
21 There are a couple of fibrotic scars and
22 calcification, lobulous. Other than that the lungs
23 look pretty good. The heart here, and again, you
24 can see the bones. So again, this is a negative
25 chest x-ray.

2109

1 Q. This is 7/1/85 on Joe Nunnally. Let's go
2 now to 11/21/88, and let's look at a x-ray film on
3 Mr. Nunnally taken at Methodist in Memphis. Tell us
4 what we see now?

5 A. Here on the 19 -- November, 1988 film,
6 you see significant changes. You see this is,
7 again, a plain chest x-ray. You can see the left
8 lung is, again, pretty normal in appearance. It's
9 homogeneously black. The lower right lung field is
10 more or less homogeneously black.

11 But in the right upper field, we have a
12 large white mass, so there is a huge soft tissue
13 dense tumor mass that is occupying that area. There
14 is a little bit something here that may be a second
15 sitting in here. Now, you can see the mass comes
16 all the way to the lateral chest wall on the side
17 peripherally.

18 You can see, however, that there is a
19 little bit of black material still here. That black
20 is still aerated lung. So there is some aerated
21 lung in the middle here.

22 Q. Let me ask you some specific questions
23 about 470 -- what's the number at the bottom?

24 A. 478.

25 Q. 478. Is the size -- does the size of

2110

1 this tumor tell you anything about its radiological
2 appearance or features?

3 A. Yes, indeed it does. This is an enormous
4 tumor. And to have survived with that size of a
5 tumor, it is very likely that we're dealing with one
6 of two types of tumor, either a lymphomatous type of
7 tumor or a sarcomatous type of tumor. The other
8 reason why this is very likely is because the tumor
9 is of what we call equal density, homogenous
10 density.

11 If it were tumors of other variety, other
12 cancers, they have the probability of becoming
13 chronic in the center. Because they outgrow their
14 vascular supply in the center, and, therefore, the
15 center of these large tumors become necrotic. So
16 they have holes in the center, and in fact, they may
17 present with neofluid levels in the center when we
18 see them on this. But to have a tumor of this size,
19 the likelihood by far is that it is a lymphomatous
20 or sarcomatous type of tumor.

21 Q. Let me just ask you directly. Is the
22 size of this tumor consistent or not with a squamous
23 cell carcinoma?

24 A. It is not consistent with a squamous cell
25 carcinoma. A patient with a squamous cell carcinoma

2111

1 of this size should be dead, should not --

2 Q. Have you, in your 40 odd years, 40 some

3 odd years of medical training, have you ever seen a
4 squamous cell carcinoma this large on presentation?
5 A. No, I have not.
6 Q. So is the size of this tumor consistent
7 with a sarcoma?
8 A. Yes.
9 Q. You've talked about the appearance -- the
10 homogenous density or the same density in the tumor.
11 Is that consistent with a squamous cell carcinoma?
12 A. No, as I said earlier, with the exception
13 of sarcomas and certain lymphomas, other malignant
14 tumors, specifically for example, squamous cell
15 carcinoma will outgrow their vascular supply.
16 Q. Which will mean what?
17 A. Which will mean they won't have blood
18 flowing into the center of the tumor. And,
19 therefore, the tumor becomes necrotic. And you end
20 up with a hole in the center of the tumor.
21 Q. You said that a squamous cell carcinoma
22 will outgrow its blood supply and leave the center
23 of the tumor necrotic or dead. Does the same thing
24 happen to a sarcoma or not?
25 A. It can, but much less likely. It happens

2112

1 to a sarcoma after treatment with chemotherapeutic
2 agents, then you kill it off, but before treatment,
3 usually not.
4 Q. Why?
5 A. Because the vascular supply of a sarcoma
6 is very different from a carcinoma. And you don't
7 have the constricting nature of the tumor on its
8 endovascular supply.
9 Q. We talked about size, we talked about the
10 density of the tumor. Is there anything else shown
11 in this -- in this x-ray of Joe Nunnally, 11/21/88,
12 that is significant to you in making a judgment,
13 radiologically, where this is a sarcoma, or squamous
14 cell or something else?
15 A. The other thing is squamous cell
16 carcinoma, more likely than not but not always, will
17 originate from the center. So the growth would be
18 from the central location in the bronchus to the
19 periphery and not from the periphery to the center,
20 although this could happen.
21 The main thing is the size is
22 inconsistent with it, the lack of cavitation or
23 necrosis is inconsistent with squamous carcinomas.
24 And the other thing, delineation, the margins are
25 these tumors is different. They can spiculated.

2113

1 The intrusions of tumors into the adjacent tissues,
2 and it looks like a cobweb, whereas sarcomas have a
3 classically smooth presentation.
4 Q. Is there any significance or not to the
5 fact that we don't see any shift in the mediastinum
6 here, making a judgment sarcoma versus squamous cell
7 carcinoma?
8 A. The main thing on that which I can show
9 you better in the next one, is squamous cell
10 carcinoma, even in much, much smaller variety would
11 have nodes. And these are disseminated tumor
12 particles to the hilar, to the regional nodes in
13 this area. And to the next stage nodes which are

14 preterenal nodes. We see no evidence of nodes here
15 which is again inconsistent with a squamous
16 carcinoma.

17 Q. You're going to have to help me on that.
18 On nodes, you're talking about lymph nodes?

19 A. Lymph nodes.

20 Q. When cancer spreads, does it do it
21 through the blood system and the lymph system at
22 least some cancers?

23 A. It can do either. It can go through the
24 blood vessels, or it can go do the lymph vessels.
25 Bronchogenic carcinoma, squamous carcinoma

2114

1 classically disseminates the mass to the lymph
2 nodes.

3 Q. Do you or not see any evidence in any of
4 these films of any dissemination of this mass to the
5 lymph nodes?

6 A. No.

7 Q. Is that consistent or inconsistent with
8 the squamous cell carcinoma?

9 A. Inconsistent.

10 Q. How much inconsistent?

11 A. Highly inconsistent.

12 Q. What is your low --

13 A. Very highly. Well, even a small -- large
14 one like that is in conceivable there would be no
15 metastases. But even a small one, lesions of three
16 centimeter and greater, that's one-inch lesions
17 that's, you know, a lesion would be about that large
18 on there, would have a better than 40 percent
19 chance. Lesions of one-and-a-half have a better
20 than 66 percent probability of nodes.

21 Q. What about a lesion of 15 centimeters?

22 A. Well, I can't answer the question,
23 because I've never seen a lesion of 15 centimeters
24 without it saying it's in but I would say it's in
25 excess of 100 percent.

2115

1 Q. Let's look at this next diagram -- not
2 diagram, x-ray 479, and there appears to be an area
3 in the middle of this that has been highlighted in
4 some fashion by -- by a special technique. What's
5 the purpose of that?

6 A. This is simply a purpose of showing the
7 area of the chorineber (sic), and showing whether or
8 not there are large nodes there. This is an
9 intensified picture of the hilar to show that here.
10 You can see the main bronchi coming down like that.
11 Then if there were nodes here, then this would
12 splay, right, it would push it apart. And this is
13 not the case. So the main thing, the main idea of
14 that exercise is to show the area and show that
15 there are no apparent nodes in this region.

16 Q. And do you see in Exhibit 479 any shift
17 of the mediastinum?

18 A. There's no shift of the mediastinum.

19 Q. Now, I want to put up a record that was
20 used earlier in the case. It's out of the hospital
21 records. And it's a report by the radiologist,
22 Dr. Routt, that was done 11/21/88. Would you --

23 A. I'm sorry.

24 Q. Would you read the opinion there, what he

25 says?

2116

1 A. The opinion is "large right upper lobe
2 mass with two smaller right lung masses as
3 described. This mass does not have the typical
4 appearance or presentation of bronchogenic carcinoma
5 and the possibility of a sarcomatous lesion is to be
6 considered. The lesion" --

7 Q. Do you agree -- I'm sorry, I interrupted
8 you. "This lesion is ready accessible to skinny
9 needle aspiration biopsy."

10 A. Biopsy.

11 Q. Do you agree or disagree with the
12 statement by Dr. Routt?

13 A. Yes, sir, absolutely agree.

14 Q. Now, next, another item that was used is
15 a report by the pulmonologist, Dr. Blythe. It's
16 dated 11/21/88, and read to the jury the impression
17 of Dr. Blythe. Before you do that, do you -- do you
18 know whether or not Dr. Blythe was the consulting
19 pulmonologist in the case?

20 A. I believe he was.

21 Q. And this Dr. Alley, do you know whether
22 or not he was the internal medicine doctor?

23 A. I believe he was.

24 Q. All right. Tell us what Dr. Blythe had
25 to say as of 11/22/88?

2117

1 A. In the impression -- "This is probably a
2 sarcomatous lesion or lymphoma. I would think he
3 would be more ill if this were an infectious
4 process, and it would be unusual for a bronchogenic
5 carcinoma to be this large at presentation, although
6 with his heavy smoking history, this is still a
7 consideration."

8 Q. All right.

9 A. "If the percutaneous aspiration biopsy is
10 not productive, it can be repeat or we can go
11 endobronchially at that time."

12 Q. Do you agree or disagree with Dr. Blythe?

13 A. I agree.

14 Q. He says this is probably a sarcomatous
15 lesion or lymphoma? Does he not?

16 A. Absolutely.

17 Q. Have you looked at the records to see if
18 Dr. Blythe ever withdraw, changed or took away or
19 canceled this opinion that he gave as of 11/22 of
20 '88?

21 A. Not to my knowledge of the records that
22 were made available.

23 Q. All right, sir. Now, if there -- if
24 there is a difference of opinion between the
25 pathologist and the radiologist, what would you do

2118

1 in your hospital? Would you just say okay, or would
2 there be some consultation to get further evidence?

3 A. No, there would be consultation. And
4 usually it could be resolved by obtaining a second
5 biopsy, usually a larger piece, chunk of tissue
6 would be removed. The thin needle aspiration is
7 extremely small, so it gives you only a few cells to
8 base your opinion on.

9 We would then go to what is called a "gun

10 biopsy" which is a spring loaded biopsy instrument
11 which takes a sliver about the size of pencil lead.
12 So there you have a good piece of tissue to look at.
13 It's about as thick as the lead of a pencil.

14 Q. All right, sir. Now, the next item I
15 want to look at with you is number 480, and just
16 tell the jury very briefly what we're seeing right
17 here, please, sir.

18 A. Now, this are then the CT slices as
19 they're generated. And they relate, then,
20 precisely, you have a number here, and this relates
21 exactly to the same number. So you can look at the
22 steering diagram, and you know exactly at which
23 level each cut has been generated to allow you to
24 orient yourself.

25 And you go -- in a chest CT, you go

2119

1 literally from the neck all the way down to the
2 diaphragm. You can then continue, obviously and go
3 to the abdomen. Then you have an abdominal CT. In
4 each case, we generate steering diagrams, so we know
5 what level we look at, and then we print it out.

6 Now, the printout in this can be in two
7 fashions. It can be in a fashion that shows you
8 soft tissue elements well, or shows you aerated lung
9 well. And this is exactly the same picture, except
10 the computer manipulates it slightly in density.
11 But these two are exactly the same. They're
12 generated from the same data. This simply allows us
13 to either look at this area in detail or look at the
14 aerated lung in detail.

15 Q. And now we've moved from x-rays to CT
16 scan, have we not?

17 A. Yes, sir.

18 Q. Done by the Methodist Hospital on Joe
19 Nunnally?

20 A. Yes, sir.

21 Q. Now, let's go to 481, and let's tell the
22 jury what we see in 481.

23 A. This is cut number 14. So we know this
24 was cut at cut number 14 level here, coming right
25 through here. So we know which area of the tumor

2120

1 we're looking at.

2 Q. Get us oriented, though, because when I
3 look at that, I don't really know what I'm seeing?

4 A. We are looking again from top now on a
5 slice. We have cut the patient like a little thin
6 slice. If you took a ban saw and cut him and cut
7 him in a slice of one centimeter thick. What you
8 see here is the sternum, the breast bone. And then
9 you see the densities here, what we call white
10 structure is dense.

11 This is all bone here. This is spine.
12 And then we come here, and you see again the black
13 area. This is normally aerated lung, normal in
14 appearance on the left side. We also have normally
15 aerated lung on the right side?

16 Q. What's the significance of that?

17 A. That there is no tumor in there. It's a
18 normal aerated lung. We have some aerated lung
19 toward the middle and posteriorly. But then we have
20 the huge mass, that's the mass that we described to

21 you that comes --

22 Q. Outline it with your finger, please?

23 A. -- from the side all the way to the
24 periphery and comes to the middle here. But it
25 doesn't reach the middle all the way. You can see

2121

1 there is some in the post aerated lung here. That
2 proves that the lesion is growing in this direction
3 and not from here to the other side. Because we
4 have normal aerated lung here. The other thing that
5 you can see here, the density of this area is about
6 the same as, for example, the density here.

7 Now, the density that you see here
8 represents muscle, so this is soft tissue density
9 which is characteristic for tumor. The fact that
10 there are no areas of difference intensity means
11 that there are no areas of necrosis. And that,
12 again, to a degree supports very strongly that
13 you're dealing with either a lymphomatous or
14 sarcomatous tumor, because squamous tumors would
15 have areas of necrosis.

16 Q. Wait. Let me make sure I understand.
17 You said squamous cell tumor would have areas of
18 necrosis. How would it appear in this Exhibit?

19 A. It would have holes in it. It would have
20 little black holes in it. It would not be of the
21 same density.

22 Q. Now, you indicated that it was
23 significant to you the direction of growth of this
24 tumor from the periphery to the center as opposed
25 from the center to the periphery. Why is that?

2122

1 A. Because a bronchogenic carcinoma
2 generally grows from the center to the periphery.

3 Q. Now, is the shape of this tumor, and I'm
4 outlining it with my finger, and I probably will do
5 it halfway right at least. Did I get it about
6 right?

7 A. Yes.

8 Q. Is the shape of that tumor, is that
9 consistent with a squamous cell carcinoma or not?

10 A. Not really. Squamous cell carcinomas,
11 again, it's much too large for a squamous cell
12 carcinoma. So it's really not consistent from the
13 very beginning. But if it were smaller, it would
14 have what we call spiculation. It has little teeth
15 that stick out. Because squamous cell tumor grows
16 into the adjacent tissue, whereas a sarcoma or
17 lymphoma in particular has a relatively smooth
18 margin.

19 Q. Okay. What -- what am I seeing right
20 here? What is this, and what is this?

21 A. Now, these are the two main stem bronchi.
22 Those are the tubes that come off the wind pipe and
23 go to the lungs, the two main stem bronchi. And the
24 importance of that is if there were nodes, which is
25 a common finding, very common finding in squamous

2123

1 carcinoma, these nodes would be sitting here, and we
2 really don't see any nodes here.

3 Q. Let me see if we can find a better
4 explanation for some of the -- some of the anatomy
5 is a little confusing to me, so maybe you can help

6 the jury with --
7 A. To show you this better, this is the
8 trachea, right, and here are these same bronchi
9 coming down. Now, we have blown up the central area
10 that I showed you there. We have done one
11 additional thing. In the addition to the right
12 stuff on the ribs and the vertebral body, you have
13 additional white stuff here now, and we have
14 introduced contrast material into the vascular
15 system.

16 And we are now pacifying the heart and
17 the big vessels. This, here, is for example is the
18 aorta, the descending koruna of the aorta. This is
19 the ascending koruna aorta, this is the pulmonary
20 artery. Now, the reason why we do that is because
21 that identifies that space here very well. And we
22 can see if there's anything sitting in here. There
23 is the koruna, the two main stem bronchi that we're
24 talking about, and there is nothing sitting in this
25 particular the area.

2124

1 Moreover, it is important to look at this
2 here that happens to be the superior vena cava, the
3 big vessel that goes to the heart. That, again, is
4 pacified and perfectly nicely oval. It is not
5 compressed. So there is no pressure effect in that
6 area whatsoever.

7 Q. And if this had been a squamous cell
8 carcinoma as contended, what would you expect to see
9 in this the area?

10 A. I would expect to see nodes here,
11 probably large nodes and nodes that possibly would
12 push the on superior vena cava. One of the
13 manifestation of squamous cell is patients blow up
14 like a pumpkin and have a blue face because the
15 blood can no longer return to the heart. It
16 compresses the superior vena cava.

17 Q. Let me ask I know a dumb question. What
18 are nodes?

19 A. Well, lymph nodes, we have two drainage
20 systems. We have an arterial and venous drainage
21 system, and we have a lymphatic drainage system.
22 Both of them serve the purpose of moving fluid
23 around. The lymph nodes are, if you wish to, a
24 sewer collection post in the drainage system, so it
25 doesn't go all the way through. They're a safety

2125

1 valve, and we catch inflammatory cells, for example,
2 in the lymph nodes so we don't disseminate the
3 inflammation and infection. So lymph nodes are very
4 important. They also catch cancer cells. That's
5 why they grow up and become metastatic, because they
6 catch the cancer cells, so they the don't
7 immediately disseminate.

8 Q. Did -- if -- you said if it was a
9 squamous cell carcinoma you would expect to see
10 nodal involvement, you would expect to see nodes.

11 A. Yes.

12 Q. What about sarcoma, would you expect to
13 see nodes or not?

14 A. No, sarcoma is classically a blood borne
15 dissemination, and we do not see nodes.

16 JUDGE CARLSON: Let's go ahead and stop

17 here. This might be a good place for a break,
18 ladies and gentlemen. You've been in place about an
19 hour and 25 minutes. So let's take a short break.

20 (A short break was taken.)

21 MR. ULMER: May I proceed, Your Honor?

22 JUDGE CARLSON: Yeah.

23 Q. (By Mr. Ulmer) Dr. Lang, let's conclude
24 our discussion of -- of the large tumor in the right
25 upper lobe with just a few questions for you. I'd

2126

1 like to ask you, first, you have indicated that
2 squamous cell carcinomas are associated with
3 smoking, I believe.

4 A. That is correct.

5 Q. And sarcomas are not associated with
6 smoking?

7 A. That is correct.

8 Q. I want to ask you, sir, if the size of
9 the tumor in the right upper lobe is consistent with
10 a squamous cell carcinoma?

11 A. No. It's too large.

12 Q. Is the size of the tumor consistent with
13 a sarcoma?

14 A. Yes, it is.

15 Q. Is the density, the homogenous density,
16 the fact that there's no necrosis in the center of
17 the tumor, is that consistent with a squamous cell
18 carcinoma?

19 A. No, it's inconsistent.

20 Q. Is it consistent or not with a sarcoma?

21 A. It's quite characteristic for a sarcoma.

22 Q. What about the -- we talked about the
23 mediastinal shift, the central structure in here.
24 Would you expect to see mediastinal shift if you had
25 a squamous cell?

2127

1 A. Yes, because it would be central, it
2 would tend to shift it.

3 Q. So the fact that there is none is not
4 consistent with squamous cell?

5 A. Not consistent, because there is no
6 shift.

7 Q. Is the fact that we have no mediastinal
8 shift consistent with a sarcoma?

9 A. Peripheral sarcoma, yes.

10 Q. The fact that we had no noticed
11 involvement, no inflammation or cancer in the lymph
12 nodes that are located immediately adjacent to this
13 mass, is that consistent or inconsistent with
14 squamous cell carcinoma?

15 A. It is inconsistent, because squamous cell
16 carcinoma would have those of metastases, not
17 inflammation, necessarily.

18 Q. Is the fact that we have no nodal
19 involvement consistent or inconsistent with sarcoma?

20 A. It's quite consistent with it.

21 Q. The direction of growth of this tumor, is
22 that consistent with the squamous cell?

23 A. It is not.

24 Q. Is it consistent with sarcoma, the
25 direction of growth?

2128

1 A. Yes, it is.

2 Q. And finally, is the shape of this tumor
3 consistent with a squamous cell carcinoma?
4 A. No, it is not spiculated or has little
5 protuberances. It is not consistent with it.
6 Q. Is the shape of this tumor consistent
7 with a sarcoma?
8 A. Yes, it is.
9 Q. Now, Dr. Lang, let's turn our attention
10 to the tumor in the right middle lobe just for a
11 very few minutes. Will you do that with me?
12 A. Yes.
13 Q. All right, sir. I want to put up 484,
14 and if you will --
15 A. This, again, here is slide number 18, so
16 you can see, this is slightly lower now at the level
17 of 18 we're cutting through here a slice.
18 And on this one, you can see this is the
19 different mode. I told you earlier, we use two
20 modes of presentation. This is the so-called
21 pulmonary mode of presentation. That's the entire
22 chest wall, everything is kind of white here. The
23 heart is white, the mediastinal structures are
24 white, and even here is some diaphragm coming
25 through.
2129
1 Now, the important thing is the left lung
2 is black. The right lung is mostly black, but there
3 is a typical mass in here, the appearance of it we
4 called it a cannon ball appearance. It looks like
5 an old cannon ball, and it does not have
6 spiculation. It has little warts, little bitty
7 rounded warts, but looks like old fashioned Civil
8 War musket ball or cannon ball. We call this a
9 cannon ball lesion which is fairly characteristic
10 for metastatic lesions to the lung.
11 Q. When you say metastatic lesion from the
12 lung --
13 A. Not from the lung, I said to the lung.
14 Q. Metastatic lesion?
15 A. Metastatic lesion to the lung. That
16 means the primary, the original tumor is somewhere
17 else. Could be anywhere, could be in the stomach,
18 could be in the bowel, could be in the bladder,
19 could be in the prostate, could be just about
20 anywhere. Any tumor that gives you metastases to
21 the lung could present with this type of cannon ball
22 lesion.
23 Q. So is it or is it not your opinion that
24 this appears to be a metastatic lesion from outside
25 the lung?
2130
1 A. Yes, it is.
2 Q. What are the most likely sources for that
3 metastatic lesion that we see here?
4 A. The most likely source for any metastatic
5 lesion of the lung in these circumstances would be
6 bowel carcinoma from the colon, and the female
7 breast carcinoma.
8 Q. What about the kidneys, is that a source?
9 A. I'm sorry, sir?
10 Q. The kidney, is that a source?
11 A. The kidney is a source, but the kidney
12 tumor, the primary kidney tumor is much less

13 commonly seen than breast carcinoma or bowel
14 carcinoma. So while it is very consistent or
15 compatible in appearance with tumors from the
16 kidney, only about two percent, where breast tumors
17 are much more common.

18 Q. What about from the pancreas?

19 A. The pancreas likewise will give you
20 classically that type of lesion if it metastasizes
21 to the lung.

22 Q. Did you read Dr. Alpert's deposition and
23 rely upon it in reaching your opinions in this case?

24 A. Yes, I did.

25 Q. Did she or not describe this as a clear

2131
1 cell type?

2 A. She described it as a clear cell type,
3 and the most common clear cell type is a kidney
4 tumor that is metastatic. So the most commonly
5 clear cell would be kidney. But there are other
6 clear cells. It can be a clear cell tumor that
7 originates from the pancreas. It can be a clear
8 cell tumor that originates from the thyroid. There
9 are be potentially other it clear cell origins.

10 Q. Where do they most often originate?

11 A. Most commonly in the kidney.

12 Q. Let me back up and make sure the jury is
13 oriented. We are not talking about the large mass
14 in the right upper lobe. We are talking about a
15 smaller tumor that's located in the middle lobe, are
16 we not?

17 A. That is right.

18 Q. And is it your opinion or not that this
19 smaller tumor is a metastasis from somewhere else?

20 A. Yes, it is.

21 Q. And is it your opinion or not that it
22 metastasized from an extra pulmonary or outside the
23 pulmonary area?

24 A. It is most likely, yes.

25 Q. And the most likely, considering that

2132
1 this is a man, where would be the most likely source
2 for that metastasis to the lung?

3 A. It most likely would be from the kidney.

4 Q. All right.

5 A. Well, no, the most likely, the appearance
6 of the mass, would depend on what we're dealing
7 with. We're dealing here with a male, so the most
8 likely would be a colon carcinoma, metastatic,
9 colon.

10 Q. Was there a definitive and positive way
11 to know where this tumor came from?

12 A. Yes. Since we know what this tumor is
13 histologically, it's a clear cell, it really
14 suggests three possibilities as high possibilities,
15 that's kidney by far the most common one, thyroid
16 the second most common one, and pancreas would be
17 the third most common one. So with this in mind, we
18 would then get together and further look in these
19 three areas to see if there's a tumor there.

20 Q. Well, would an autopsy have resolved the
21 issue or not?

22 A. Yes.

23 Q. Now, do clear cell -- do the clear cells

24 arise as a primary in the lung?

25 A. No.

2133

1 Q. All right, sir. Now, did you -- did you
2 look at the CT and other radiological evidence from
3 other parts of the body to try to make a
4 determination as to where this tumor came from?

5 A. Yes, there were additional CTs of the
6 abdomen. We have here a cut of the abdomen. Now,
7 that cut is actually a little lower than my table
8 here indicates. It would be at about this level
9 down here. So we're a little bit lower now. We
10 don't have a scan ground for that area. But that
11 cut would be about this level, about this level of
12 the abdomen.

13 MR. MERKEL: Excuse me, Dr. Lang. May we
14 approach, Your Honor?

15 THE WITNESS: Sure.

16 MR. MERKEL: Pardon me for a minute while
17 we take something up with the Court.

18 (Off-the-record discussion.)

19 Q. (By Mr. Ulmer) Dr. Lang, you can step
20 back down.

21 JUDGE CARLSON: Step back down.

22 Q. (By Mr. Ulmer) All right. We're looking
23 at Exhibit 486, and you were telling the jury, I
24 believe, about where this is located on the body.

25 A. This cut was approximately through this

2134

1 section of the abdomen. (indicating.) So what we
2 see on this specific part, we see again the lower
3 parts cut along here, the white area here, is,
4 again, a bony structure, the spine. And then we see
5 a fairly large, relatively light area over here.
6 That's the liver. We see another relatively light
7 area over here that is the spleen.

8 JUDGE CARLSON: Excuse me, Doctor. You
9 may need to speak up a little bit. Not only the
10 jury can hear you the court reporter has to hear
11 you, too.

12 A. The relatively light area is the spleen,
13 denser white area is the upper part of the kidney.
14 The reason that is denser because it's concentrated
15 dye we have injected. You see the white area here,
16 that is the passive aorta, major blood vessel, and
17 when you look at this, you can see again there is a
18 white area going forward. That white area is the
19 cilia artery which is the main blood vessel we have
20 to supply kidney, spleen and stomach, and there's a
21 direct vessel going over to the liver.

22 I'm sorry, I said kidney, I meant liver,
23 spleen and stomach, and you can see that there's a
24 direct vessel straight going over toward the liver
25 that is the so-called pan artery, and then there's a

2135

1 vessel going over to the spine, but that vessel
2 doesn't go straight. It should go from here over to
3 here. It's behind the spleen. It doesn't do that.
4 I'm sorry. Can you see it? It doesn't go straight,
5 rather in there it kind of bends to the back. So
6 there must be a reason why it is bending to the
7 back, and the reason for that is that there appears
8 to be a mass in this area that you see.

9 Q. (By Mr. Ulmer) What is that area?
10 A. That area is the region of the body and
11 tail of the pancreas. So there appears to be a mass
12 in the region and body of the tail of the pancreas.
13 Can I use the other one?

14 Q. You have prepared a medical illustration
15 that's anatomically correct, and based on Exhibit
16 486.

17 A. I think this will perhaps show it a
18 little bit easier. That's simply the same thing
19 drawn out. See here your liver, you see here the
20 spleen. You see here the upper bowl of the kidney.
21 Now, here very importantly in red you see the aorta.
22 And from the aorta goes the vessel to the front,
23 that is the celiac artery, and that gives off two
24 vessels, one to the liver, the other to the spleen.
25 And the third one happens to go to the stomach,

2136

1 which we don't have on here. But you can see
2 instead of going straight where it's supposed to go
3 in here, it bends backwards.

4 So on basis of the spleen, basis of this
5 bend, we can say it has to be something sitting in
6 front, otherwise it wouldn't bend backwards, and
7 that implies we're dealing with a mass in the
8 pancreas.

9 Q. Do you have an opinion to a reasonable
10 degree of medical certainty if there was a mass in
11 the pancreas?

12 A. Yes.

13 Q. And what is that opinion?

14 A. That there was a mass.

15 Q. Do you know whether or not the mass that
16 is shown in Exhibit 486 was ever appreciated or
17 found on -- on review by the Methodist Hospital?
18 Was this mass ever recognized by the Methodist
19 Hospital?

20 A. Well, it's obviously there. This is
21 their film. They didn't particularly describe it.
22 But yes, it's on their film.

23 Q. All right, sir. Do -- we talked about
24 sarcomas, which are not related to smoking, and
25 squamous cell carcinomas which are related to

2137

1 smoking in this large mass and right up below.
2 We've now in the last 15 minutes focused on this
3 cannon ball shaped metastasis in the middle lobe.
4 Is it your opinion or not that this was a metastasis
5 from some source outside the lung?

6 A. Yes.

7 Q. And you had indicated earlier that there
8 were a number of different the potential sites,
9 based on what's shown in Exhibit 486, do you have an
10 opinion, based upon a reasonable degree of medical
11 certainty, as to whether that mass, the right middle
12 lobe came from the pancreas?

13 A. This is the most likely thing. We have
14 no finding of another abdominal mass, bowel mass.
15 We have a finding that there's a mass here. So this
16 is probably the primary for the metastatic lesion in
17 the right middle lobe.

18 Q. And we talked about Dr. Alpert's
19 description of this as a clear cell type cancers, do

20 clear cell type cancers arise in the pancreas?
21 A. They can.
22 Q. Do they arise in the kidney?
23 A. They very commonly arise in the kidney.
24 Q. Is that sometime called renal cell
25 cancer?
2138
1 A. Yes, renal cell carcinoma, renal cell and
2 granular cells, and bronchocytic cells.
3 Q. What -- for pancreatic cancer, what is
4 the likely patient outcome for pancreatic cancer?
5 A. It is almost uniformly lethal, the
6 patient dies, moreover, the survival is extremely
7 short, survival once a mass of this size is
8 diagnosed of approximately 6.2 months.
9 Q. I only have just a few more questions for
10 you, Dr. Lang. Joe Nunnally, at diagnosis, I
11 believe, was 36 years of age, and his death was 37
12 years of age. Is it rare for a person of that age
13 to have cancer in the lung?
14 A. Yes.
15 Q. Describe the rarity or the lack of rarity
16 of that.
17 A. Well, again, it depends what you call
18 cancer in the lung. If it's a metastases, for
19 example, from a tumor metastases, it is not rare.
20 Because that occurs mostly in younger individuals,
21 you would find but primary lung cancer would be
22 extremely rare.
23 Q. Let me ask a better question, then. Is
24 it rare or not to have a primary lung cancer in the
25 lung at 36 to 37 years of age?
2139
1 A. Yes, it's extremely rare.
2 Q. On the order of? When you say "rare,"
3 that means different things to different people.
4 Have you ever -- have you ever had a patient in your
5 40 some odd years present with a primary lung cancer
6 at 37 years of age? When I say "primary," I mean
7 starting in the lung.
8 A. No.
9 Q. All right, sir. Now, we talked about
10 metastasis, that is where a piece of cancer like an
11 embolism breaks off and travels through the blood or
12 lymph system somewhere else. Is the lung a common
13 site for metastasis?
14 A. The lung is one of the common sites; the
15 liver is the other common site.
16 Q. Why is the lung a common site for
17 metastasis?
18 A. Because it is, in essence, a filter.
19 When the cells get disseminated in the bloodstream,
20 they have to be circulated to the lung. Because our
21 entire blood goes through the lung to be oxygenated.
22 Now, the small vessels in the lungs where the
23 exchange for the oxygen takes place can very easily
24 result in stopping these tumor cells there.
25 So once they stop them there, then the
2140
1 tumor grows there. So it's like a filter. You're
2 sending these cells through a filter. And the two
3 filters we have in the body or the three filters is
4 the liver, where the blood gets filtered through,

5 and the cells get stuck, and more metastases, and
6 the lung where the exchange for oxygen takes place,
7 and the lymph nodes, and those are the three filter
8 areas where we see metastases.

9 Q. Final two questions. Do you have an
10 opinion based upon a reasonable degree of medical
11 certainty as to whether or not the large mass in the
12 right upper lobe was a squamous cell carcinoma?

13 A. I do not think it was a squamous cell
14 carcinoma.

15 Q. Do you have an opinion as to what it was
16 most likely?

17 A. Most likely a sarcoma.

18 Q. Do you have an opinion based upon a
19 reasonable degree of medical certainty, as to
20 whether the smaller tumor in the right upper lobe
21 was from the lung or metastasized to the lung from
22 some other site?

23 A. Most likely metastases to the lung.

24 MR. ULMER: Tender the witness's, Your
25 Honor. Before I tender the witness's, Your Honor,
2141

1 let me offer into evidence certain of these
2 exhibits. We will not offer the medical
3 illustrations, but -- and not to slow things down,
4 if I could just provide the numbers now, and maybe
5 let Mr. Merkel proceed, then I'll substitute smaller
6 copies into the record. Would that be permissible?

7 JUDGE CARLSON: Yes, sir.

8 MR. ULMER: We offer Exhibit Awn-477 and
9 Awn-478, 479, 480, 481, 482, 484, 486. And we would
10 like to offer a copy of Dr. Lang's CV which is
11 AN-001128, and finally, we offer 474 as well. I
12 overlooked it.

13 MR. MERKEL: The only one we object to,
14 Your Honor, is 482 which has medical illustration
15 superimposed on it.

16 JUDGE CARLSON: Yes, sir.

17 MR. MERKEL: This one right here. Object
18 to that.

19 JUDGE CARLSON: I'll permit it to be
20 marked along with the others. The objection will be
21 noted. The exhibits will be marked and received
22 into evidence.

23 CROSS EXAMINATION BY MR. MERKEL:

24 MR. MERKEL: Proceed, Your Honor?

25 JUDGE CARLSON: Yes, sir.
2142

1 Q. (By Mr. Merkel) Dr. Lang, other than
2 Mr. Ulmer's hand written job here, I'm kind of
3 fascinated by the quality of your defense boards
4 here. Did you have these made or --

5 A. Yes, sir, they were made in New York
6 City.

7 Q. New York City. How much did they cost
8 R. J. Reynolds to get this whole collection made?

9 A. I didn't pay for it.

10 Q. Well, \$10,000 or --

11 A. Counsel may have the figure. I -- I have
12 no idea. I selected and approved the drawings. And
13 there was a medical illustrator in New York City who
14 I approved the drawings and worked out the drawings
15 with him. He presented a bill not to me, but he

16 presented it to the attorneys. So they paid for it.
17 I have no idea what they paid for it, sir.

18 Q. Did you go to New York City and work with
19 him on how you wanted all of this displayed and
20 demonstrated?

21 A. It so happened that I was a guest
22 professor at SUNY, downstate medical center, and it
23 was convenient for me to meet in his office in New
24 York City. I happen to be up there fairly frequent,
25 and I met him up there. That is correct.

2143

1 Q. Let's talk a little bit, Dr. Lang, about
2 cancer in general, and metastasis in particular. Am
3 I right that the primary cancer comes before the
4 metastasis?

5 A. Yes, sir.

6 Q. And how long does it normally take a
7 cancer to grow enough to the point that it
8 metastasizes and appears somewhere else?

9 A. This is extremely variable. But the
10 presence of metastases does relate to the size of
11 the primary tumor. The size of the primary tumor
12 relates to the growth rate, which is different for
13 different tumors.

14 Q. Well, you've been telling us throughout
15 all of this what the classic this is or the
16 generally appearance of this, that and the other.
17 There's nothing really -- all tumors are very
18 different in how they appear, and how they
19 metastasize and where they go; is that not true?

20 A. They have a fairly characteristic what we
21 call "pattern" on the basis of which they identify
22 themselves, yes.

23 Q. But they have a lot of variability, too,
24 don't they, in fairness, Dr. Lang?

25 A. They have variability, but there is some

2144

1 type specific nature to tumors. And we call it a
2 signature pattern of a tumor. And it is one of the
3 classical things that you teach young physicians to
4 recognize. That a tumor with a certain appearance
5 very likely is that type of tumor that foreshortens
6 the amount of examination that is necessary to
7 establish a definitive diagnosis. Because it leads
8 you in the proper pathway.

9 Q. Well, using that criteria again instead
10 of telling me variable, how big they have to be,
11 what is the classic signature, how big does a tumor
12 have to be in the order to metastasize?

13 A. Generally very small. We see tumor
14 metastases with tumors of a half an inch, certainly
15 tumors of the size of one inch have a very high
16 probability of being metastatic. But there are
17 tumors of a half an inch size that are already
18 metastatic.

19 Q. Now, if we're going again by the classic
20 norms, Dr. Lang, how long does it take a tumor to go
21 from whatever size it starts to 15 centimeters?

22 A. Just depends on the doubling time of the
23 tumor. Some tumors have a faster doubling time.
24 Others have a slower doubling time. For example, if
25 you have a slow growing tumor, a carcinoma of the

2145

1 prostate, it would take enormously long to grow to
2 that size. On the other hand if you take, for
3 example, a very malignant cancer of the female
4 organs, cora carcinoma, it takes a half a year, six
5 months, and they grow to enormous size.

6 Q. Well, we don't have a female here.

7 A. Correct. That's why I say each tumor has
8 a very specific pattern by which we can identify it,
9 it's characteristic in growth speed. It's
10 characteristic in contour appearance. They're very
11 characteristic.

12 Q. Let's talk about the possibilities in
13 Mr. Nunnally's case. You just give me all the types
14 of tumors you think it could possibly be, and then I
15 want to know how long it took it to grow from origin
16 to the 15 centimeters in each instance.

17 A. Well, we see --

18 Q. Typically, again, and I understand
19 there's variability, but you've been giving
20 Mr. Ulmer typical all afternoon, and that's what I'm
21 like looking for.

22 A. Precisely, sir. We have two reference
23 points. We have reference point of 1985 where we
24 have a chest film, and I see nothing on it. We have
25 a reference point of 1988 three years later where we
2146

1 have an enormous tumor there. This mandates that
2 this is something that grows very rapidly. And
3 sarcomas, classically can do that. Now, lymphomas
4 can do that. So the two probabilities for that
5 would be a sarcoma or lymphoma to grow that fast.

6 Q. Take them apart. How long does it take a
7 sarcoma to go from nothing to 15 centimeters?

8 A. That can be achieved certainly in a
9 period of two-and-a-half years, no problem.

10 Q. Two-and-a-half years. All right. How
11 about a lymphoma?

12 A. Could even be less than that.

13 Q. Sir?

14 A. Could be less than that.

15 Q. Well, two years, year-and-a-half, best --

16 A. Year-and-a-half, two years.

17 Q. Okay. And it could also be a -- a
18 squamous cell carcinoma, I suppose?

19 A. Squamous cell carcinoma, number one,
20 doesn't grow that fast.

21 Q. Well --

22 A. And number two --

23 Q. Excuse me just a second, doctor -- I'm
24 not asking --

25 MR. ULMER: He's trying to finish.

2147

1 MR. MERKEL: Trying to save time.

2 MR. ULMER: He's trying to finish his
3 answer, Your Honor.

4 JUDGE CARLSON: Go ahead and answer the
5 question.

6 A. A squamous cell carcinoma does not grow
7 that fast, number one. And number two, a squamous
8 cell carcinoma will kill a patient much before it
9 reaches the size. Because a squamous cell carcinoma
10 has a very high probability of early metastases to
11 lymph nodes, and the patient would long be dead

12 before it reaches this size.

13 Q. (By Mr. Merkel) Well, I was not asking
14 you, Doctor, for your opinion about whether it was
15 or whether it wasn't. I'm saying hypothetically
16 speaking how long would it take a squamous cell
17 carcinoma to grow to 15 centimeters?

18 A. I have no reference for that. There is
19 nothing in the literature that I know of that gives
20 you reference that a squamous cell carcinoma has
21 grown to 15 centimeters in a live patient, and it
22 doesn't grow in a dead patient.

23 Q. Okay. Any bronchogenic carcinoma,
24 Dr. Lang?

25 A. 15-centimeter bronchogenic carcinoma, any
2148

1 bronchogenic carcinoma would, in great likelihood,
2 kill the patient before it reaches 15 centimeter.
3 Number one. Number two, a bronchogenic carcinoma by
4 nature of the blood vessels that this tumor has
5 would have loss it's blood supply and would have
6 become necrotic. And the patient would have
7 acquired infection or tumor load, and he wouldn't be
8 alive. I have no reference point to give you,
9 because we don't see them that large, sir.

10 Q. I'm confused. Is Dr. Joseph Blythe here
11 when he says, "It would be unusual for bronchogenic
12 carcinoma to be this large at presentation, although
13 with his heavy smoking history, this is still a
14 consideration," I mean, is he just dumb as dirt when
15 he says that?

16 A. I thought he says it's unusual.

17 Q. I know, be he says it's still a
18 consideration, and you seem to be telling us this is
19 just ludicrous.

20 A. Well, would you -- would you explain the
21 term "unusual" to me. Unusual means it isn't
22 encountered, right, he isn't saying --

23 Q. It's not the common, I agree with that.
24 When he says --

25 A. What is your percentage of unusual? Do
2149

1 you have percentage values of unusual. I would say
2 in our language means generally less than two
3 percent. This is what you call unusual.

4 Q. Well, then why is --

5 A. It is anecdotal or unusual in medical
6 terminology or -- unless you offer me a different
7 question, I don't know how to answer your question.

8 Q. You say you're familiar with the records?

9 A. Yes.

10 Q. What he says, "It would be unusual for
11 bronchogenic to be this large at presentation."

12 A. Right.

13 Q. "Although with his heavy smoking history,
14 this" -- being bronchogenic carcinoma -- "is still a
15 consideration." Now, my question to you, is he an
16 idiot, or is it still a consideration?

17 A. No, sir, he says it is unusual that a
18 bronchogenic carcinoma is that large at
19 presentation. Now, the second portion of the
20 sentence, I interpret that with heavy smoking
21 history, there is occurrence of bronchogenic
22 carcinoma.

23 I agree with both of his statement, heavy
24 smoking history, high occurrence, high, certainly a
25 high probability of bronchogenic carcinoma, first

2150

1 portion it's unusual that bronchogenic carcinoma is
2 that large as presentation. It means less than two
3 percent probability in medical jargon.

4 Q. Unusual is less than two percent?

5 A. That's what we call unusual.

6 Q. I see. Where is that contained in some
7 medical work, Dr. Lang?

8 A. Sir?

9 Q. Where is that definition of that word
10 contained in some medical work you could give me to
11 look up?

12 A. This is something that we use for
13 reporting. And everybody knows that when we use the
14 term "unusual" or "anecdotal," it occurs in a rare
15 instance. "Rare" we define is less than two
16 percent. It still can occur.

17 Q. Let's say for the sake of my question,
18 then, if you'll humor me, this is one of those two
19 percent shots. How long can it take for a
20 bronchogenic carcinoma to grow to 15 centimeters if
21 it was one of those two percent chances Dr. Blythe
22 is looking at?

23 A. I would -- if a patient could survive
24 that amount of tumor load, we are talking here of an
25 enormous tumor load. If he could survive it, I

2151

1 would say it would have to be probably in excess of
2 multiple years. I don't know how many.

3 Q. Again, two?

4 A. Sir, I just tried to explain to you, I
5 can't give you a scientific answer, because there
6 are no data from that.

7 Q. All right.

8 A. All the patients that have a tumor that
9 large we find at autopsy, they are dead. So we have
10 no data. I know of no data that the I can offer you
11 for that. You're giving me a supposition that is
12 deprived of any scientific basis.

13 Q. I see. Well, if it's, as you've opined,
14 a metastatic tumor that's gone to there. And if it
15 took it two-and-a-half years to get to this size,
16 assuming as you say, it's a sarcoma, then that means
17 it had to be a pancreatic tumor more than
18 two-and-a-half years previously, didn't it?

19 A. I'm not saying this is a metastasis from
20 the pancreas, sir. I'm saying this is a sarcoma. I
21 think the second lesion in the middle lobe was what
22 I believe I said, I hope I didn't misrepresent it,
23 was the lesion that I think is from the pancreas.

24 The lesion up there is so large that
25 there are only really two points that the come in

2152

1 consideration, that is lymphoma or sarcoma. The
2 lesion in the middle lobe is what I -- I hope I
3 didn't confuse you -- but the lesion in the middle
4 lobe is the one that I think is a metastatic lesion
5 from the pancreas.

6 Q. So we just coincidentally, at the same
7 time we've got a pancreatic cancer we've got this

8 sarcoma that's been growing there two-and-a-half
9 years, and that just came from two different places?

10 A. Yes, sir, coexisting tumor is recognized
11 in the medical literature.

12 Q. Does the medical literature recognize,
13 Dr. Lang, that tumors can metastasize from one spot
14 in the lung to the same lung?

15 A. Yes, sir, they can.

16 Q. And they can go from one lung to another
17 lung?

18 A. Yes, sir, absolutely.

19 Q. And does the medical literature recognize
20 that you can have bronchogenic tumors that don't go
21 into lymph nodes?

22 A. Yes, sir.

23 Q. And this tumor, if it were clear cell,
24 the small one, as Dr. Alpert said. And in fact,
25 what Dr. Alpert said is that was not diagnostic of
2153

1 anything. But it had some clear areas in the cell,
2 and that those could come from the lungs, or the
3 pancreas, or the liver or the stomach, I believe she
4 said, did she not, Doctor?

5 A. I don't recall the precise wording. I
6 have it as clear cell.

7 Q. Did you read her deposition, Doctor?

8 A. Yes, sir.

9 Q. Do you recall it when you were testifying
10 about --

11 A. Yes, sir.

12 Q. -- what she said about clear cell?

13 A. Yeah. But please refresh my memory. I
14 have it as clear cell, and that's as close as I
15 could come.

16 Q. Well, in fact, she said that clear cell
17 wasn't even a type of cancer, did she not, sir? May
18 I approach, Your Honor?

19 JUDGE CARLSON: Yes, sir.

20 Q. (By Mr. Merkel) She first touches on
21 it -- well, this may not be the first. Right here,
22 you gave an answer that clear cell can come from the
23 lungs, the kidneys or stomach I believe was another
24 area that you suggested. "In the first place, is
25 there any evidence that any of the cells were clear
2154

1 cell carcinoma in any of the specimens?" She says,
2 "Many of the cells in the second nodule have a clear
3 appearance, so when you call it clear cell
4 carcinoma, you're not saying very much. You're just
5 saying that the cells have clear cytoplasm, and
6 there can be several causes for that. It does
7 not -- there can be several causes for that."
8 "Among those, what would the causes be for that
9 appearance?" She says, "A lot of glycogen can cause
10 clear cell appearance, a lot of fat can cause clear
11 cell, a lot of ribosomal --

12 A. Dilatation.

13 Q. "dilatation can cause a certain
14 granulation in clear cell appearance." Question:
15 "So the existence of cells with clear cell
16 appearance, is that in any way diagnostic of this
17 being clear cell carcinoma, that alone." Answer:
18 "Your question suggests to me the use of the word

19 clear cell. It's not clear to me. It sounds like
20 you're using that word as if clear cell carcinoma
21 has a particular significance." She then goes on to
22 say, "It's a descriptive terminology, and when you
23 have something that looks clear and appears to be a
24 carcinoma as opposed to a sarcoma or lymphoma, the
25 fact that it's clear is a descriptive word and

2155

1 allows you, then, to pursue, if you choose, to the
2 refigure what is causing the clearness of those
3 cells. We proceeded here with PAS stains and found
4 that there was glycogen." Now, am I not reading
5 that correctly, Doctor?

6 A. Yes, you're reading that correctly. I am
7 not certain that the inference that is given from
8 it. She's describing a clear cell.

9 Q. What she --

10 A. Clear cell carcinoma is a descriptive --
11 is a descriptive entity. Now, if you wish to argue
12 with the pathologist on the various appearance of
13 clear cell, please do so. I won't pick you up on
14 that. I can say one thing. If you have fat in the
15 cell, okay, we can stain fat. We have specific
16 stains for that. There are specific stains for
17 glycogen.

18 Q. She did that, Doctor.

19 A. So you can process that. I don't know
20 whether she -- I saw no reference that she stained
21 for fat and found or did not find fat. Refresh my
22 memory on that. I don't know what fat stains she
23 did.

24 Q. All right, Doctor. Did she say right
25 here, "So the existence of cells clear appearance is

2156

1 that in any way diagnostic," she says again, "I seem
2 to be suggesting that she's calling it clear cell."
3 She says, "It's a descriptive terminology, and when
4 you have something that looks clear, you can test.
5 We pursued it here with PAS stains, tests for
6 glycogen."

7 A. That's for glycogen. I'm trying -- you
8 just quoted me a minute ago other possibility,
9 namely fat, Sudan 3 if you the don't know it is the
10 proper stain for fat. Did she do the Sudan 3 stain?
11 I'm asking you.

12 Q. Did she do a glycogen stain, Doctor, and
13 find it to be positive in the small tumor?

14 A. She did not find anything positive on
15 glycogen.

16 Q. You're saying -- excuse me. Let's don't
17 talk over each other.

18 A. Okay.

19 Q. Are you telling the jury that she did not
20 find glycogen in the small tumor?

21 A. She did a glycogen stain.

22 Q. Did she find it?

23 A. She did.

24 Q. Was it positive or negative?

25 A. Apparently, it was positive.

2157

1 Q. Apparently. Have I convinced you of
2 that, or do you remember that, Doctor?

3 A. Well, let me remind you, sir, that she

4 gives three different options, okay. She calls it
5 clear cell which for me as an oncological physician
6 implies a clear cell tumor. She gives a number of
7 possibilities for clear cell. To illusivate on the
8 clear cells, and I'm not a expert staining in
9 pathology. She gives on stain which goes to
10 glycogen. I'm just telling you, another sustain,
11 classical stain that's used today is Sudan 3 that's
12 used for fat. I know of no reference that she
13 stained for fat. You know, what are you saying? I
14 don't know.

15 Q. Well, I'm trying to find out partly what
16 you know, Doctor. Did she do one stain or two
17 stains for glycogen?

18 A. Apparently one stain.

19 Q. You don't have to do two stains to
20 determine glycogen?

21 A. There are multiple different staining
22 techniques. I'm not an expert on the staining
23 techniques. I know the basic stains that are used.
24 There are many very complex stains. There is
25 modality of electronmicroscopy to further illusivate
2158

1 on that. As far as I know, there was no electron
2 microscopy done on this specimen, so that wasn't
3 processed this way. The reason why it wasn't, I
4 cannot tell you. I don't know.

5 Q. Let's try this, Doctor, to find out
6 whether there's glycogen there, do you have to do a
7 PAS stain first, and then a PAS stain with digestion
8 to see if the glycogen or color disappears?

9 A. I believe that's correct.

10 Q. So there's actually two stains to
11 determine that, aren't there?

12 A. I recall of one. She may have done two.
13 If you say so, I certainly accept it. But both of
14 them are glycogen stains. I do not think she did a
15 Sudan 3 stain or did she? Refresh my memory. I may
16 be defective in my memory.

17 Q. The jury has heard all what Dr. Alpert
18 said, Doctor.

19 A. Okay.

20 Q. We'll worry about that later.

21 A. Okay.

22 Q. As far, Dr. Lang, what you're saying
23 here, if I understand it now, only the small tumor
24 metastasized.

25 A. I'm sorry, sir.

2159

1 Q. Only the small tumor what you're telling
2 the jury, you think metastasized from this pancreas
3 that had the primary in it?

4 A. I said that the pancreatic lesion
5 metastasized to the middle lobe.

6 Q. The small tumor in the middle lobe?

7 A. The small is a metastasis, yes, sir.

8 Q. The other one is not now, so we won't be
9 confused anymore about that.

10 A. No.

11 Q. The big one didn't metastasize?

12 A. The large one is more unlikely to be a
13 metastases, moreover, there was a suggestion it was
14 sarcoma, histopathologically, too.

15 Q. Unquestionably, Doctor, if it had been a
16 metastasis, and it had grown to that size and it
17 start in the pancreas as you suggest, Mr. Nunnally
18 would have been dead from the pancreatic lesion long
19 before it got to 15 centimeters?

20 A. I fully agree with you.

21 Q. And the fact the longevity of pancreatic
22 cancer is as low as three months from diagnosis,
23 isn't it, sir?

24 A. Three to six months, yes.

25 Q. And does pancreatic cancer show any other
2160

1 symptomology as it advances and the patient continues
2 to be eaten up and killed by pancreatic cancer?

3 A. The location an as you indeed imply, it
4 does. If the tumor is in what we call the head of
5 the pancreas, it will obstruct the bile ducts, and
6 the patient will present with jaundice.

7 Q. Do we have any of that in the record,
8 Doctor, anything that shows he's jaundiced?

9 A. No, the tumor was in the tail of the
10 pancreas. It would not obstruct the bile ducts,
11 because they enter in the head of the pancreas, and
12 it there would be no opportunity to obstruct them.

13 Q. What were the symptoms that it was in the
14 tail? How would the patient or doctor know
15 that's where it was?

16 A. Frequently pain is the first symptom that
17 these patients experience.

18 Q. Can you find anywhere in the record where
19 he complained of pain in that area of his abdomen?

20 A. Not -- not particularly no, sir.

21 Q. And if he was dying of pancreatic cancer,
22 he should have tremendous pain there, shouldn't he?

23 A. The majority of patients I have seen had
24 severe pain, indeed this is correct.

25 Q. You told us, Doctor, what "unusual" means
2161

1 in your medical vernacular. What does "impression"
2 mean?

3 A. That's a summary of the component of the
4 report above. You summarize it.

5 Q. Well, does it mean that's what you think
6 it could be at that time?

7 A. Yes.

8 Q. It's not a diagnosis yet, is it?

9 A. No, it's not a definitive diagnosis.
10 It's the impression of the information you have
11 above summarized.

12 Q. And if you go through the process in a
13 hospital with a specialist consulting and all of the
14 team getting together like you said. This comes way
15 before diagnosis, doesn't it?

16 A. That is correct, sir.

17 Q. And what was the diagnosis in this case
18 at Methodist Hospital in Memphis, Dr. Lang?

19 A. Well, the diagnosis was an inoperable
20 tumor.

21 Q. What kind, Doctor?

22 A. Their initial diagnosis, I think, on
23 basis was a sarcoma. The radiologist read it as a
24 probable sarcoma.

25 Q. I thought this was an impression, Doctor.

2162

1 A. This is the pulmonologist. There is a
2 radiologic report from the same hospital.

3 Q. Let's look at it. These are your two
4 boards.

5 A. Uh-huh.

6 Q. Now, this is an opinion.

7 A. Yeah.

8 Q. And it says the mass does not have the
9 typical appearance of presentation of bronchogenic
10 carcinoma. Now, what does "typical" mean?

11 A. Typical mean --

12 Q. What percentage is that?

13 A. Typical is high percentage, which we
14 express usually in the range of greater than 66
15 percent, that's high percent.

16 Q. 66 percent. Okay. So he said it doesn't
17 look like 66 percent of them. And the
18 possibility -- now, that's less than 50 percent, I
19 guess, possibility, isn't it?

20 A. That is correct. Possibility would be
21 less than 50 percent.

22 Q. And the possibility of a sarcomatous
23 lesion is to be considered.

24 A. Yeah.

25 Q. Now, this was all done on 11/22?

2163

1 A. Yeah.

2 Q. Right? And this impression was done on
3 11/22, correct?

4 A. Yes.

5 Q. And by 11/29, the date of discharge, what
6 was the diagnosis, Doctor? Number 1 right here.

7 A. It was expressed as squamous cell
8 carcinoma.

9 Q. Okay. Which of those impression, opinion
10 and diagnosis carries the most medical weight in
11 health facilities all over this nation?

12 A. The discharge diagnosis should
13 incorporate all the diagnostic criteria. However,
14 if there is a disparity in the expression of
15 probabilities of diagnosis, then additional tissue
16 should be obtained until you can solidify the
17 diagnosis that's usually the procedure in every
18 major hospital. However, if the hospital feels that
19 this is adequately expressed and, then this is
20 listed as the discharge diagnosis.

21 Q. Do you see anything here, Doctor, that
22 the Methodist Hospital in Memphis is acting like a
23 bunch of incompetent turkeys or something?

24 A. No, not at all.

25 Q. So would you assume that Dr. Blythe who

2164

1 once thought his impression was that it was probably
2 a sarcoma, and Dr. Routt who once said that it was
3 the possibility of a sarcoma, do you think they all
4 got in teamwork and conjunction with the treating
5 physicians and came to this diagnosis?

6 A. I don't know that. I would certainly
7 feel that their diagnosis was much more reasonable
8 than the data that they had. And in the
9 institutions that I have worked in, we would have
10 pursued it much further, because you have two

11 physicians who expressed the probability diagnosis
12 that is very reasonable and explains the thing very
13 well and would have deserved to be pursued.

14 Now, on the other hand, if there is
15 something that came up that made them come to this
16 diagnosis, then, indeed, you enter it as your final
17 diagnosis.

18 Q. We would certainly hope, wouldn't we,
19 Doctor, that the medical profession would pursue it
20 further to reach the right result if they were
21 trying to save a man's life --

22 A. Oh, absolutely.

23 Q. -- than if they were in Court trying to
24 testify for a Defendant that it was something other
25 than the medical record said?

2165

1 A. Well, I don't know. I'm looking at the
2 medical records, too, unless you disenfranchise the
3 radiology report that is a medical record. I felt
4 that is a medical record.

5 Q. Well, there's the pathology report,
6 doctor. What does it say it is?

7 A. "Poorly differentiated squamous
8 carcinoma."

9 Q. And that is on the date 11/23, the next
10 day after these things.

11 A. Uh-huh, yeah.

12 Q. After they got the pathology.

13 A. Yeah.

14 Q. What does this one say on 11/23, Doctor?

15 A. "Poorly differentiated squamous
16 carcinoma." So they copied the report from that,
17 which is reasonable.

18 Q. What does this one say on?

19 A. If you allow me to help you, that's a
20 billing code. This is where the billing code is
21 printed out.

22 Q. That would have been done at the end of
23 the case, I suppose, 11/29, then.

24 JUDGE CARLSON: Give me just a minute, do
25 you need to check on something?

2166

1 COURT REPORTER: I need to check my
2 paper.

3 Q. (By Mr. Merkel) January the 13th, 1989,
4 Dr. Lang, what was the diagnosis then, nearly a
5 month later?

6 A. The same diagnosis, for obvious reason,
7 once you have the diagnosis entered as final
8 diagnosis, you copy it until it is altered for
9 whatever reason.

10 Q. And when he got to Houston, this was
11 diagnosed as squamous cell carcinoma. This is in
12 March of '89.

13 A. Right.

14 Q. What was he treated for, Doctor?

15 A. Well, I think the treatment, basically,
16 was for a lesion that was considered inoperable, and
17 the treatment was very reasonable.

18 Q. Does treatment for sarcoma differ from a
19 carcinoma, Doctor?

20 A. In most instances, yes, I would probably
21 have deployed chemotherapy earlier. But this was a

22 very large lesion. And what the physicians did,
23 namely to use radiation therapy in order to shrink
24 it down was a perfectly reasonable attempt.

25 Q. Well, going back to your "usuals" that
2167

1 you've been testifying to Mr. Ulmer about, what's
2 usually done, was this treated as a sarcoma or
3 carcinoma, Doctor, in the usual context?

4 A. The first treatments, the treatment at
5 Methodist --

6 Q. The radiation treatment.

7 A. The radiation therapy in Memphis I think
8 was certainly directed as a treatment for a large
9 anoplastic carcinoma.

10 Q. Not the sarcoma?

11 A. No, sir, I don't think so.

12 Q. If we put Mr. Ulmer's chart up here, and
13 if we put another column up here, that said,
14 "treatment," was it consistent with squamous cell,
15 we would say yes. And sarcoma, we would say no?

16 A. Not entirely. I think it was more
17 consistent and more appropriate for large carcinoma,
18 yes, sir.

19 Q. Would you use chemotherapy with large
20 sarcomas, Dr. Lang?

21 A. Yes, sir.

22 Q. What is M. D. Anderson? Are you familiar
23 with that facility?

24 A. Yes, sir.

25 Q. That's not a bunch of turnip truck guys
2168

1 out there, is it, Doctor?

2 A. It's an outstanding institution.

3 Q. Did they do a resection?

4 A. To the best of my knowledge, no.

5 Q. You don't think they did a resection of
6 his lung?

7 A. No, sir. I know of no resection that
8 they did at M. D. Anderson.

9 Q. Dr. Lang, you don't know that
10 Mr. Nunnally was operated on in Houston, Texas?

11 A. Yes, he was. He was operated at Baylor
12 University, not at M. D. Anderson, sir.

13 Q. Was he sent to M. D. Anderson, Doctor,
14 not the actual facility he was operated on, but who
15 did the work out there, who worked him up and
16 followed him?

17 A. I don't know, sir. The records indicate
18 that Methodist Hospital, Baylor University. If he
19 was operated at M. D. Anderson, it's another
20 operation. I've not seen a record of that. I don't
21 know of nothing that he ever has been at M. D.
22 Anderson from the records that I saw.

23 Q. Okay. Wherever he was treated in
24 Houston, Texas, Doctor, was he resected?

25 A. Well, I'm sorry, you lost me. I mean, if
2169

1 you know of a second treatment that was instituted,
2 I haven't seen it. I haven't seen those records. I
3 know that he was resected at Methodist Hospital.

4 Q. Okay.

5 A. Which is a component of Baylor
6 University.

7 Q. Without regard, Doctor, to where the
8 facility is, what hospital it's done in, he was
9 resected, correct?

10 A. At -- to my knowledge.

11 Q. Yes, sir.

12 A. At Methodist Hospital at Baylor
13 University, he was resected, yes, sir.

14 Q. And is a resection done for any kind of
15 metastatic lesion?

16 A. Yes.

17 Q. You think that if somebody has metastatic
18 lung cancer, they will do a resection?

19 A. Yes, sir, very frequently, and I refer
20 you to specific articles, for example, "Skinner,"
21 that's 15-year-old. There are literally hundreds of
22 articles that recommend resection, segmental
23 resection of a solitary or multiple metastasis a
24 menial to resection, of concomitant resection of
25 tumor, the most commonly practiced procedure in the
2170 United States. And most certainly the procedure
2 that would be practiced at M. D. Anderson had he
3 been there.

4 Q. You think that would be the norm?

5 A. Yes, sir.

6 Q. If we thought this was a metastatic the
7 lesion, we would resect it?

8 A. If you had a melt static resection,
9 solitary or multiple that is a menial to resection
10 of the lung, and the primary lesion can be resected,
11 specifically, for example, renal cell carcinoma,
12 clear cell carcinoma, that is the treatment of
13 choice in the United States, in Europe, and in many
14 parts of Asia. It is replete in the literature.

15 Q. And do you think that if anybody
16 suspected it had pancreas as origin, they would do a
17 resection of any kind, would they, Dr. Lang?

18 A. On the pancreas, they would not. No,
19 sir.

20 Q. In fact, they seldom operate on the
21 pancreas, itself, if it's involved, do they, Doctor?

22 A. There are specific operations.

23 Q. There is a procedure.

24 A. There are specific operations. They are
25 classically designed operations on the carcinoma,
2171 the head of the pancreas. They are rarely used,
2 because usually it's too advanced by the time you
3 find it.

4 Q. And you found nothing in this record
5 anywhere that any of these facilities ever
6 considered any pancreatic lesion in him, did you,
7 sir?

8 A. No, sir, but then, I haven't seen any
9 records of M. D. Anderson. So if you have
10 additional records, I haven't seen those, so I don't
11 know.

12 Q. Now, this little red blood vessel you
13 have drawn here, Dr. Lang --

14 A. Yes, sir.

15 Q. -- that you said you think has been
16 pushed out of the way by this tumor in the pancreas,
17 correct?

18 A. Yes, sir.
19 Q. Do all our blood vessels just -- in every
20 one of us, all 12, 14 jurors, whatever, does
21 everybody's go just exactly like they're supposed to
22 go, Doctor, all the time?

23 A. No, they can be variant. None of them,
24 however, are curvaceous. They don't make bows and
25 bends for no reason. If they have a bend in them,
2172

1 then there is a reason. And the reason is usually
2 that there is a space occupied lesion or a mass
3 there that forces them to bend.

4 Q. Anything at all that you told Mr. Ulmer
5 and the jury earlier today that's any kind of
6 cutting edge pathology that people in Memphis at the
7 Methodist Hospital there shouldn't know about,
8 Doctor?

9 A. Please repeat the question. I didn't
10 understand it.

11 Q. Anything about your testimony and your
12 explanation today that is so cutting edge and so
13 intricate that the pathologist, board certified
14 pathologist in Memphis, Tennessee, shouldn't be
15 aware of it?

16 A. No, sir.

17 Q. How about in Houston, Texas?

18 A. No, sir.

19 Q. Should they be aware of everything you're
20 saying?

21 A. I'm certain the pathologist there is an
22 excellent pathologist, I'm sure.

23 Q. So they ought to be able to see the same
24 size of the lesion you did?

25 A. I think so, sir.
2173

1 Q. What does "periphery" mean, Doctor?

2 A. Periphery is the outside of any given
3 area.

4 Q. Well, on this chart of the lung here, you
5 started pointing every time around here. And then
6 you kind of went around like that. Is the periphery
7 just on this side, or is it on this side, too?

8 A. The periphery is circumferential, sir,
9 all the way around. For example, if you take an
10 apple, to make it very simple. The edible part of
11 the apple is the periphery. The core of the apple
12 is what is left over, that's in the center. So the
13 periphery is circumferentially around it.

14 Q. So this is periphery over here, and this
15 is periphery over here?

16 A. Yes, sir, on the rim.

17 Q. It's not just on this outside, it's also
18 over here?

19 A. No, sir, absolutely not.

20 Q. So I guess, Doctor, if we had a tumor
21 that started out the size of a be-be or a marble,
22 and it grows, do they generally grow in all
23 directions, expand?

24 A. Generally, it does.

25 Q. They don't start at one edge and just the
2174

1 other edge runs out like this unless something is
2 confining it and trapping it?

3 A. Precisely, if it is confined from con
4 side, like, for example, the thoracic cage, then
5 obviously, unless it penetrates the thoracic cage,
6 the bones, which is unlikely, it has to grow the
7 other way, because it can't expand. It doesn't have
8 any space.

9 Q. But if it does what they normally do, it
10 would expand in every directions at once, just
11 becomes a bigger ball, and a bigger ball, and a
12 bigger ball?

13 A. Absolutely, that is correct.

14 Q. In this board here, number 478, Doctor.

15 A. Yes, sir.

16 Q. This white stuff is the tumor?

17 A. Yes, sir.

18 Q. From out here to over here?

19 A. No, a little bit less. You can see that
20 there is lung cutting in.

21 Q. This is bone, spinal column or whatever
22 through here.

23 JUDGE CARLSON: You need to go down,
24 Doctor?

25 A. May I step down, sir? What you have here
2175

1 is the white stuff is tumor, but you can see that
2 there's aerated lung coming in here. You see the
3 shade of gray.

4 Q. (By Mr. Merkel) I see a little down
5 here. What about up here is where I'm looking?

6 A. Up here it is overlapping, because you
7 have a very large mass.

8 Q. This tumor here, Doctor, that we see in
9 white stuff, that is tumor?

10 A. Right up here, this is tumor, yes, sir.

11 Q. And it stretches all the way from the rib
12 cage to the center part of the body, the spine,
13 whatever you want to call it?

14 A. Well, not quite. If you look, as you can
15 classically see, this area is lighter, okay. So
16 this area of lung here, moreover, I have showed that
17 to you on the CT cut. You can see the area of lung
18 coming in here. There is tumor that is very large
19 and overlapping. And this is an intermediate
20 effect. So if you want to look at this, we can look
21 at the CT cut.

22 Q. All I'm asking you, Doctor, on this one,
23 is this white stuff from here to here tumor?

24 A. This is homogenous tumor. Here it is a
25 combination.

2176

1 Q. I didn't ask you here, Doctor, right
2 here.

3 MR. ULMER: Your Honor.

4 Q. From there to there, is that tumor.

5 JUDGE CARLSON: Hold it. We've got three
6 people talking at one sometime.

7 MR. ULMER: That was my objection is that
8 Mr. Merkel continues to talk over the witness, and
9 we object to that, and also, it's Dr. Lang, L-A-N-G.

10 MR. MERKEL: I'm sorry, Your Honor. They
11 furnished him to us as Dr. Land.

12 Q. (By Mr. Merkel) I'm sorry, I haven't
13 meant to insult you by that, Doctor. They gave us

14 your name L-A-N-D.

15 JUDGE CARLSON: Let's have question and
16 response one at a time, okay.

17 A. The question as I understand it is this
18 homogenous tumor. The answer is no. Because this
19 area is dense, this area is less dense, so you have
20 lung shining through partially, and you get what is
21 called a partial volume. In order to the clarify
22 that and not confuse you or confuse us. That's why
23 we did a CT cut, and on the CT cut, we can see that
24 there is normal lung on this. That's the reason for
25 the CT. Otherwise both you and I could be confused
2177

1 and could assume that the tumor extends all the way
2 to the side.

3 Q. (By Mr. Merkel) My question, quite
4 simply, again, Doctor, not about homogenous, not
5 about anything else, is white stuff from here to
6 here indicative of tumor, yes or no, please?

7 A. The answer is it is partially indicative,
8 since it is less dense, it is not so indicative. If
9 you have a composite. All I can tell you is gray,
10 this area is grayish, this area is whitish, you
11 know.

12 Q. And if it's less dense, then the jury can
13 see it's less dense just like you and I can.

14 A. Correct.

15 Q. Thank you. Doctor, is it your considered
16 opinion that everything that Methodist did with
17 regard to diagnosis and treatment of this patient
18 was wrong?

19 A. No.

20 Q. If I wanted you to appear as an expert
21 for me in a malpractice case against them for
22 misdiagnosing his sarcoma and treating it as a
23 bronchogenic carcinoma, would you do it?

24 A. No, sir, I don't think it was all wrong.
25 They had an enormous tumor burden, and they
2178

1 instituted treatment because of the tumor burden. I
2 think there was absolutely nothing wrong that they
3 did. If anything, they could have expanded on their
4 diagnostic efforts. I am not certain it would have
5 made any difference whatsoever.

6 Because a carcinoma of the pancreas, he
7 would not have survived. I don't think anybody did
8 him any wrong. Neither the first institution nor
9 did Baylor University did him any wrong in Houston.
10 And if he was at M. D. Anderson and something was
11 done there as you allege, which I don't know, I
12 don't think they did anything wrong to him.

13 Q. You disagree with their diagnosis, you
14 say it's not bronchogenic carcinoma?

15 A. I do not think it's bronchogenic
16 carcinoma, no.

17 Q. You disagree with their treatment,
18 because they didn't treat the him for sarcoma?

19 A. No, I don't. I think it was a treatment
20 option that was probably not optimal. But didn't do
21 him any harm and may have prolonged his life to some
22 degree. Possibly chemotherapy might have been
23 slightly superior, but I think as matters stand the
24 poor gentleman was doomed one way or the other.

25 They did the best in both institutions and possibly
2179
1 also at the Anderson, if a third resection was
2 carried out. I don't see anything wrong with any of
3 the treating physicians. They did their best under
4 the circumstances.

5 Q. They used the wrong diagnosis and the
6 wrong treatment, but it just didn't make any
7 difference?

8 A. Well, sir, there are unfortunately
9 certain stages of diseases, where no matter what we
10 do, we cannot save the patient. And under these
11 circumstances, our attempts are to the ameliorate
12 symptomatology. It didn't really make that much
13 difference. There would be some response to
14 radiation therapy. They elected radiation therapy
15 first. The second group elected chemotherapy, and I
16 think that was a good choice. I don't think either
17 group was at fault.

18 MR. MERKEL: Nothing further, Your Honor.

19 JUDGE CARLSON: Redirect?

20 MR. ULMER: Just a few questions, Your
21 Honor.

22 REDIRECT EXAMINATION BY MR. ULMER:

23 Q. The large tumor that was in the right
24 upper lobe, you have described it as a sarcoma.

25 A. Yes, sir.

2180

1 Q. And not a squamous cell carcinoma.

2 A. Yes, sir.

3 Q. And Mr. Merkel, I think, was confused
4 about -- is it your contention that the sarcoma
5 metastasized from outside the lung to there, or did
6 it originate in the lung?

7 A. Sarcomas are blood borne tumors. They
8 could come, from for example, osteogenetic sarcoma.
9 They could come from the bone. They could originate
10 in the interstitial tissues of the lung. They could
11 come from cartilage. It doesn't make much
12 difference. They are sarcomatous legions spread by
13 the bloodstream.

14 Q. The metastasis you talked about, it came,
15 I believe you gave the jury your opinion it came
16 from the pancreas to the right middle lobe?

17 A. Most likely.

18 Q. Is that the metastasis you were talking
19 about as opposed to the large tumor in the upper
20 lobe?

21 A. Yes, sir.

22 Q. Is it your opinion or not there was a
23 metastasis from the pancreas that went to the right
24 middle lobe?

25 A. Yes, sir.

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1 Q. And is it your opinion or not that the
2 large tumor in the right upper lobe was a sarcoma?

3 A. Yes, sir, it is.

4 Q. How certain and how firm are you in that
5 opinion?

6 A. By size of the tumor, by lack of necrosis
7 in the tumor, by the appearance of the rim of the
8 tumor and by the fact that the patient was alive, it
9 was most likely a sarcoma.

10 Q. All right, sir. Now, Mr. Merkel asked
11 you if you knew that the radiologist, Dr. Alpert,
12 out in Houston, Texas, had diagnosed this as
13 squamous cell carcinoma. Tell the jury what the
14 radiologist -- I mean the pathologist in Houston
15 determined the cell type to be.

16 A. Well, to the best of my knowledge, she
17 determined it that the one that came from the middle
18 lobe was clear cell, and the other one was most
19 likely, again, a sarcoma.

20 Q. Let me ask you this specifically, did --
21 and you may not know this. And if you don't, that's
22 okay. Did the pathologist, Dr. Alpert, in Houston,
23 actually get the fine needle aspirant slides from
24 Memphis and look at those slides?

25 A. To be honest, I don't know.

2182

1 Q. You don't know.

2 A. -- on what basis she made the diagnosis.

3 Q. Do you know -- well, if you don't know
4 that, you wouldn't know the next question. With
5 respect to the treatment provided by Memphis, did
6 Memphis treat this as an operable tumor or not?

7 A. No, they treated it as an inoperable
8 tumor.

9 Q. All right. Do you -- do you know the
10 circumstances that took Joe Nunnally from Memphis
11 where they would not operate to Houston, Texas,
12 where they did operate?

13 A. Well, I presume he did what most patients
14 do, and very reasonably so, he wanted a second
15 opinion. And Houston has a very good reputation, so
16 he went to Houston to get a second opinion.

17 Q. Is it unusual for one institution to say
18 that it's inoperable and we won't operate, and yet a
19 second institution, second hospital, follow up and
20 do the surgery. Is that unusual or not unusual?

21 A. It's really not that unusual. Because
22 for one reason, when you get into more extensive
23 surgery, one or the other hospital may be more
24 prepared to do it and will be more attuned to do it.
25 The other thing is any procedure, irregardless of

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1 what is done, is not done on the dogma of the
2 physician, but is done on the request of the
3 patient.

4 You tell the patient what you think could
5 be done. And then the patient decides whether he
6 wants to have it done or not, and it is the
7 patient's perfect right to decline it or request
8 something. It is his privilege to determine the
9 treatment, not the physician determines the
10 treatment.

11 Q. Just a final thing. And tell the jury
12 if, in your opinion, based on all the evidence that
13 you've seen, and you've studied and you've
14 considered, based on all the evidence, it is your
15 opinion, to a reasonable degree of medical
16 certainty, that the large tumor that was located in
17 the right below Joe Nunnally was a sarcomatous
18 lesion?

19 A. Yes.

20 Q. And is a sarcomatous lesion associated

21 with smoking?
22 A. Not to my knowledge.
23 Q. All right. Final thing. The metastasis
24 that you've described in the middle lobe, the coin
25 shaped or --
2184
1 A. Cannon ball.
2 Q. -- cannon ball shaped metastasis that the
3 jury has seen on CT in the right middle lobe, do you
4 have an opinion based on a reasonable degree of
5 medical certainty, do you have an opinion whether
6 that metastasis came from the lung or from outside
7 the lung?
8 A. From the outside the lung.
9 Q. Where is your opinion?
10 A. From the evidence we have, we can only
11 incriminate one area, and that would be the tail of
12 the pancreas.
13 Q. All right, sir. And you were describing
14 to Mr. Merkel, you know, unfortunately the doctors
15 don't get involved until it's, in effect, too late.
16 What would be the likely outcome for the patient of
17 a sarcomatous lesion this large and in combination
18 with a metastasis from the pancreas?
19 A. I think he is unfortunately doomed to
20 die.
21 MR. ULMER: Thank you, Your Honor. We
22 have nothing further.
23 JUDGE CARLSON: Is Dr. Lang finally
24 released?
25 MR. ULMER: Yes, sir.
2185
1 JUDGE CARLSON: Thank you, Doctor.
2 You're released. I know you're ready for a break.
3 Let me confer with counsel before we do that.
4 (Off-the-record bench conference.)
5 JUDGE CARLSON: All right. Ladies and
6 gentlemen, what I was trying to determine, since --
7 based on the lateness of the hour, as to who the
8 next witness might be and how long the next witness
9 will take. I don't think you want to hear how long
10 it might take, but long enough to I know you don't
11 want to stay here into the evening to hear the next
12 witness.
13 I mean, it would take too long, and
14 you've put in a full day, so instead of working you
15 well into Friday night, I'm not going to do that. I
16 think I would be breaking my promise to you if I
17 said we'd keep on a schedule roughly 8:30 to 5:00
18 o'clock everyday as best I could, recognizing we
19 might stop a little early or a little past 5:00 if
20 we could get through with a witness. But this next
21 witness would not fall into that category as far as
22 getting through, you know, a little after 5:00.
23 So let's go ahead and stop here for the
24 weekend, and we'll move forward, and if we are off
25 schedule, at this point, I don't think we would be
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1 that far off schedule, still try to go ahead and
2 move forward to a conclusion next week. Hopefully
3 the early part, middle part of next week as far as
4 getting the case to you.
5 So let's go ahead and stop here for the

6 weekend. The only thing I need to remind you of, of
7 course, is please not discuss the case, make any
8 effort to gain any outside information, read any
9 news articles, save that until after the trial.
10 Hope y'all have a good weekend, and we'll see you
11 Monday morning at 8:30.

12 (Jury exits courtroom.)

13 JUDGE CARLSON: Let's go ahead and take a
14 short break, and we'll go forward in just a few
15 minutes.

16 (A short break was taken.)

17 (Exhibits 474, 477, 478, 479, 480, 481,
18 482, 484, 486 and AN-001128 marked for
19 identification and entered into evidence.)

20 JUDGE CARLSON: I understand that the
21 next witness that will be called which will be
22 Monday morning, there's to be objections to be taken
23 up on that testimony?

24 MR. LISTON: Yes, sir. For the record,
25 we'll announce that the identity of that witness is

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1 Dr. George Seiden.

2 JUDGE CARLSON: All right, sir.

3 MR. MERKEL: Your Honor, Dr. Seiden, we
4 have been furnished expert interrogatory response
5 with regard to him. He is apparently a psychiatrist
6 and going to testify based on his exhibits about a
7 whole lot of different definitions of addiction, and
8 habituation and such things as that which is not
9 really the subject matter of our problem. The
10 generic stuff is not.

11 They state, also, that Dr. Seiden will
12 testify regarding the evidence of Mr. Nunnally's
13 personality, intelligence, ability to discern
14 messages, to make decisions and to follow through on
15 his decisions. He will also address his awareness
16 of risks of his personal life-style choices.
17 Dr. Seiden will demonstrate throughout his life
18 Mr. Nunnally had the ability to control his
19 behaviors, make reasoned decisions, accept
20 responsibility for his decisions and change his
21 behavior to the extent he chose to.

22 And then the grounds for that is he bases
23 his opinion and testimony on his education, training
24 and experience, his review of the existing evidence,
25 including Mr. Nunnally's medical records,

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1 depositions and other evidence in this proceeding,
2 and his review of other pertinent scientific
3 literature.

4 And it's that last part that I just read
5 that we -- and I understand we don't have a --
6 Dalbert does not apply directly in Mississippi, but
7 I think the Court still has a gate keeping function
8 to keep patently invalid expertise from being
9 presented to the jury. And I would like to have the
10 witness tendered whatever it is he wants to say in
11 this regard, Your Honor, outside the presence of the
12 jury so the Court can rule on it.

13 I don't think there's any way possible a
14 psychiatrist can tell us what a person who he has
15 never met or talked to or seen. And all he has are
16 squibs from memories of friends 30, 35, 40 years in

17 the past who say I think he knew this or I think he
18 understood that because I did and things like that.
19 I mean, that just to me as patently ridiculous that
20 a psychiatrist would base a supposed learned opinion
21 on that type of criteria. If he's something else,
22 then I stand to be corrected.

23 But they've given us some copies of the
24 squibs that he's going to rely on, and some of the
25 more important ones are "Is there any doubt in your
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1 mind Joe knew about the risks that were being
2 reported about cigarette smoking?" Answer: "I
3 think he knew. I think we all knew, knew the
4 risks." "Was Joe Nunnally aware of the health
5 risks?" "I think he would have been aware of it as
6 most of us are." And those kind of answers are
7 apparently what he's basing his testimony on, Your
8 Honor, and that's just not the subject of a proper
9 psychological or psychiatric formation of a proper
10 psychiatric opinion, I would say.

11 JUDGE CARLSON: Mr. Liston? Do you have
12 a response?

13 MR. LISTON: Yes, sir, Your Honor.
14 Dr. Seiden is a psychiatrist, and he specializes in
15 the fields of dependency, substance abuse, and those
16 fields. And he will offer an opinion based upon
17 that information that has been brought forward
18 either by depositions that he's read of the
19 witnesses in this case, or testimony that's been
20 given in this case concerning those issues of
21 whether or not Mr. Nunnally had the ability to stop
22 smoking and whether he could smoke.

23 And if fact -- and as I take it this is
24 the really the graviment of Mr. Merkel's objection
25 is he can't testify because he never saw
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1 Mr. Nunnally, and he's basing it on what his friends
2 and relatives said about it, and that's a crazy way,
3 as Charlie, I think, is saying to present that. But
4 Your Honor, it isn't.

5 We do it everyday in the courts of
6 Mississippi. In will contest test cases,
7 psychiatrists take the stand, and based on what
8 people say about the person who left the will, these
9 psychiatrists have been accepted by the Court as
10 experts to testify whether the person had
11 testamentary capacity based on his acts, and if he
12 knew what he was doing and recognized his
13 surroundings and those things. So it's certainly
14 not anything new that -- a methodology that the
15 Dr. Seiden is going to the utilize in this case to
16 reach his opinion.

17 There are many instances that this
18 happens in. In insurance cases where there's a
19 death and the insurance company claims that the
20 insured committed suicide. And the same process is
21 done by psychiatrists for both sides in cases like
22 that, that are accepted as experts. They give
23 opinions based on what the friends and relatives of
24 people that knew these people saw.

25 And they'd get on the witness stand, and
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1 they'd testify, and have never seen this person,

2 never knew the person in their lifetime. And there
3 are just numeral instances -- numerous instances
4 where that type testimony is allowed. And it sort
5 of surprises me that the Plaintiff has an objection
6 to this. But I think the proper way to do this, if
7 the Court has any doubts at all, is Monday the first
8 thing that we're going to do is put Dr. Seiden on
9 the witness stand and go through his qualifications
10 to do this. And we feel sure that after that
11 examination that Mr. Merkel can voir dire him at
12 that time and make the objection at the correct
13 time. That that's the way that we should proceed
14 with this.

15 I wouldn't ask the Court right now to
16 make the decision to say yes, he can testify to
17 that. I don't think that's fair to the Court to do
18 that. I think you've got to hear his
19 qualifications, his experience and his training and
20 what he's done with his professional life to qualify
21 him to give these opinions, which will be of aid to
22 the jury in this case.

23 JUDGE CARLSON: Anything further?

24 MR. MERKEL: Basically, Your Honor, it's
25 not whether he's a qualified psychiatrist that I'm

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1 challenging, and it's not that under some
2 circumstances he might not be able to get enough
3 information in some fashion to do it. But when he's
4 relying on statements like did he enjoy smoking?
5 Answer: "Obviously, he did." "Did he tell you --
6 was he one of those people that smoked because he
7 liked to smoke?" Answer, "He enjoyed smoking. It
8 gives you something to do with your hands, I guess."

9 And you heard Mr. Fischer questioned who
10 opined about several things, and then he admitted he
11 didn't have any idea what he was talking about, he
12 was guessing about certain things. And that's what
13 we've got, and besides that, about half of the data
14 that's been given to us as forming the basis of his
15 opinion isn't in this record. Witnesses have come,
16 gone, testified, and they didn't say the things that
17 are in here. And obviously, that would have to be
18 culled out, too, not something that was read in some
19 deposition that is not before this jury.

20 MR. LISTON: Well, that's not right,
21 either, Your Honor. Under the expert rules of
22 evidence, a witness can base his opinion on matters
23 that were related to him extra judicial proceeding
24 statements. Certainly he ought to be able to read a
25 deposition that was taken at the case, in that very

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1 same case where that witness was under oath. And
2 the test is whether or not professionals in that
3 field ordinarily rely on that source of information
4 to make day-to-day decisions in their practice, and
5 we meet that. It doesn't have to be from the
6 witness's stand in here.

7 MR. MERKEL: If it was so unreliable,
8 Your Honor, that it couldn't be gotten to the
9 witness stand, it should not be relied on by a
10 witness to tell the jury that I'm relying on
11 something that the jury hasn't heard, and if they'd
12 have tried to get it in, they wouldn't have been

13 able to get it in such as assumptions and guesswork,
14 and gee, I don't know, but if you wanted me to
15 guess, I'll say probably he did or things like that.
16 And that's the type -- type stuff we're looking at
17 in most of this. And if it hadn't come in at all
18 even to that extent, then it shouldn't be reliable
19 enough for him to base some off-the-wall opinion on.

20 MR. LISTON: I submit that goes to the
21 weight and not the admissibility.

22 JUDGE CARLSON: I think the question, the
23 best way to handle this would be to put the witness
24 on the stand Monday morning and go through it in the
25 normal procedure. Have the Defendant attempt to

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1 qualify him, voir dire him, go from there. I think
2 under Rule 703, it states clearly that facts and
3 data relied on totally or in part by the expert
4 witness need not be admissible into evidence. I
5 think clearly under Rule 702 and 703, that would be
6 the appropriate way to do it. Anything further of
7 this Court?

8 MR. ULMER: I'm afraid to bring it up,
9 Your Honor, but I don't think it will take long. We
10 have previously provided to the Court and counsel
11 opposite stipulations from the pretrial order that
12 we want to read, and I understand there's no
13 objection to that. We have provided to the Court
14 and to counsel opposite responses to requests for
15 admission that we want to read. And Mr. Merkel has
16 indicated he objects to some of these requests for
17 admissions, and I'll give you an example.

18 The first request for admission that we
19 want to read to the jury, and there are a number of
20 them, "Admit you have no evidence or knowledge that
21 Plaintiffs' decedent Nunnally ever saw, read or had
22 read to him any statement by R. J. Reynolds that
23 cigarette smoking was healthy for you."

24 We want to read that to the jury because
25 it has been made relevant by the statements and the
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1 evidence that's been put in by the Plaintiff. The
2 Plaintiff has put before the jury that through
3 advertisements, through testimony by Burns, and
4 through other means that he did hear things that
5 were put forth by R. J. Reynolds, and so we're
6 perfectly entitled -- if we had a witness on the
7 stand, we could ask that you have no evidence that
8 Joe Nunnally ever heard or saw these things.

9 So his objection is to the way it's
10 framed, that there is no evidence. But the fact
11 that the Plaintiff has no evidence is a very
12 important fact when they have made that issue and
13 made that contingent here. So Your Honor, we would
14 like to get that resolved now so that when the jury
15 does get back here, we could proceed to read the
16 requests for admissions stipulations that I
17 previously served counsel with, and with some
18 interrogatories as well.

19 Now, I don't know of any objections to
20 anything except for the request for admissions that
21 are framed along the lines of you have no evidence
22 or knowledge.

23 JUDGE CARLSON: Let me make sure just for

24 the record that we get clear, these were tendered to
25 me previously, these reviewing, when I'm using the

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1 last three numbers, 48968, there's no objection to
2 that?

3 MR. MERKEL: No objection, Your Honor,
4 about the stipulations, that part of the pretrial
5 order.

6 JUDGE CARLSON: Right.

7 MR. MERKEL: These are all those things
8 that they tried to include in the pretrial order and
9 Your Honor ruled were not appropriate for inclusion
10 in the pretrial order. Now they're trying to get
11 them in by trying to read them in as some admission.
12 Our position is they are not facts. They're not
13 facts for a jury. They never were facts. They were
14 not even properly a subject for request for
15 admission, because they were not a fact.

16 JUDGE CARLSON: Time out. Make sure
17 we're clear. 489, stipulations and admissions.

18 MR. MERKEL: May I come up, Your Honor,
19 and look? I don't have it. I didn't know this was
20 coming up, and I don't know where mine is.

21 MR. ULMER: I have an extra set if you'd
22 like it.

23 MR. MERKEL: We don't have any problem
24 with any of these, Your Honor.

25 JUDGE CARLSON: And then 492 was

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1 interrogatory response to what is 493. I'm saving
2 the best for last. I know where the objections are.
3 That's what I'm trying to get these other dealt
4 with.

5 MR. MERKEL: We don't have any problem
6 with the interrogatories, our answers, such as they
7 were, being published.

8 JUDGE CARLSON: Okay. And 493.

9 MR. MERKEL: As far as the state and time
10 when they were done the, there's no problem with any
11 of that, no, sir. Now, it's all these other things.

12 JUDGE CARLSON: 494 and -- let me just
13 make a few comments on this. I guess I recall the
14 story that was told on Judge Cady at some point when
15 he was sitting there all intent listening to
16 testimony, all of a sudden the question was asked,
17 and he's on the bench, and he says, "I object."

18 And he thinks for a second, he says,
19 "Objection sustained." It's almost like I have to
20 say I kind of object to some of this, but I know we
21 dealt with this pretrial. And a lot of time spent
22 on -- in going through and what had been admitted or
23 not admitted, and what responses were complete or
24 not complete or inconsistent. I recall the Court
25 entered orders and directed the Plaintiff to amend

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1 its answer -- answers to requests for admissions.

2 Let me tell you where I see all this
3 going. And I have to say -- and maybe memory fails
4 me. But I don't I don't ever recall, and I may have
5 said this along the way, all these years on dealing
6 with requests for admissions, I don't ever recall
7 requests for admissions being admit that you have no
8 evidence of this or admit that you have no evidence

9 of that. It's always admit this fact or admit this.
10 You know, is it a fact or not. I think that's the
11 purpose of the rule, Rule 36, to get all this
12 undisputed stuff out of the way, not to waste time
13 proving a fact that's not in dispute.

14 So we get into admit that you have no
15 evidence, and it almost puts the Plaintiff in the
16 position of proving the negative where you'd have to
17 call in the world population to prove the negative.

18 MR. MERKEL: That's exactly my point,
19 Your Honor.

20 JUDGE CARLSON: Also, it comes to light,
21 especially over a period of time when I've been
22 reading the jury instructions. And when you get to
23 admit that you have no evidence of this or that.
24 And then the Defendant, and it will be interesting
25 seeing any authority for it, but when the Defendant

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1 proposes instruction D-5 that says, "Since Plaintiff
2 has the burden of proof, she is required to produce
3 the most explicit, direct and satisfactory proof
4 available with respect to the cause of Joe
5 Nunnally's cancer and death, or the presumption that
6 if more satisfactory evidence had been given, it
7 would have been detrimental to her case.

8 If you believe from the evidence that
9 more explicit, direct and satisfactory evidence was
10 available to the Plaintiff, then that than that
11 which was produced, then you are justified in
12 presuming that such evidence had been produced by
13 the Plaintiff, it would have been adverse to the
14 Plaintiffs' claim that smoking caused Joe Nunnally's
15 cancer and death." Y'all may be able to prove me
16 wrong, but I thought this instruction that -- I know
17 I've given many times in years past, that somewhere
18 along the way, the Supreme Court has now condemned
19 this instruction. Am I correct?

20 MR. MERKEL: I think you are, Your Honor.

21 MR. ULMER: Charlie is of right mind to
22 agree with the Court right now, Your Honor, which is
23 real unusual, I might add. I hadn't seen a lot of
24 that up to this point.

25 JUDGE CARLSON: Classic example. Used to
2200

1 happen in -- I know Bill doing a lot of Plaintiffs
2 work can recall, and from the defense side, too, the
3 defense would admit the treating physician that the
4 Plaintiff didn't call. That old instruction if the
5 Plaintiff didn't call their own doctor, if called
6 you can presume it would have been detrimental to
7 her case. That used to have been given all the
8 time. I really believe that instruction has been
9 condemned.

10 MR. MERKEL: It went out the window, Your
11 Honor, when the privilege was waived as to medical
12 conditions that a person was putting at issue in the
13 lawsuit. The Court said the reasoning or rationale
14 behind it is, either side can bring that evidence.
15 So there's no indication by the Plaintiff not
16 bringing the doctor that it's adverse to him,
17 because the Defendant's equally able to bring the
18 doctor.

19 JUDGE CARLSON: That's where I see we're

20 going with all these requests for admissions. And
21 if the Court permitted these to be read to the jury,
22 of course, this instruction would be submitted. And
23 I can't imagine of a jury getting more confused
24 over, you know, what if -- what if all this evidence
25 may have been out there, if it --

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1 MR. MERKEL: And the rule --

2 MR. ULMER: If I could say one thing.

3 Charlie has had the floor all the time.

4 MR. MERKEL: I didn't know I had said
5 anything, Mike.

6 MR. ULMER: You've had the floor more
7 than you deserve.

8 JUDGE CARLSON: Let me hear Mr. Ulmer.

9 MR. ULMER: I'm not here to defend jury
10 instruction number 5. I don't really know. I
11 don't --

12 MR. MERKEL: He's not the lawyer for that
13 one.

14 MR. ULMER: It may be wrong. But I'll
15 tell you this, these requests for admissions are not
16 wrong for a whole bunch of reasons. But the first
17 reason was when we were arching about the pretrial
18 the order, they didn't want them in the pretrial
19 order. They said they don't go in the pretrial
20 order. I have the transcript where Mr. Merkel says
21 if he want to read them, let them read them in their
22 case. But the Court observed I'm not going to give
23 you the hammer of putting this in the pretrial the
24 order. I think I remember that correctly, and I
25 think the transcript will bear that out.

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1 Second thing, much more substantive than
2 that, if the Plaintiff hadn't tried the case the way
3 they tried the case, with innuendo, about things
4 that are not in the case, it would be totally
5 unnecessary to tell the jury what they don't have
6 any evidence of. That's the reason for these, and
7 why I think under these unusual circumstances, and I
8 agree with the Court, it is oddly phrased. But
9 under these circumstances we have here, it's unfair
10 to let them throw a stinking, rotten fish over in
11 that box and say we can't do anything about it.

12 You can't come back and say Plaintiff you
13 tried the case on three weeks what Nunnally may have
14 known from R. J. Reynolds, but they've admitted they
15 don't have any evidence at all of that. That would
16 be unfair. Your Honor, I hope I wasn't
17 disrespectful about getting the floor from
18 Mr. Merkel. I positively meant none towards you,
19 maybe only a little bit towards Charlie. But not
20 much, I can assure you.

21 JUDGE CARLSON: Okay.

22 MR. ULMER: I think these are entirely
23 fair under the circumstances here.

24 MR. MERKEL: Your Honor, they're
25 improper. They're entirely improper, because they

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1 are not facts. They're a statement as to the state
2 of the evidence on a certain day six months ago, or
3 nine months ago or a year ago or whatever date is on
4 the things.

5 Any evidence that has gone before that
6 jury, whether I got it on cross examination, they
7 put it on an or I put it on is before that jury.
8 And if one of these stupid things says that nine
9 months ago we didn't have any evidence that this,
10 that or the other happens, and now there's been
11 three witnesses get on the stand and say something
12 that meets evidence in that regard, it would just be
13 totally ridiculous to read that. And it is not a
14 fact.

15 The only thing that could have anything
16 to do with would be going towards a summary judgment
17 if they asked us do you have anything that you
18 haven't seen, or we haven't been given in other
19 discovery, admit that there is nothing else going to
20 this issue. And we admitted there was nothing else,
21 they could bring before Your Honor, then, a motion
22 for summary judgment on whatever that was. But that
23 is not evidence to go to the jury. The jury's the
24 judge of what the evidence is, circumstances,
25 direct, cross examined evidence put on by them or by
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1 us.

2 And what we could have proven five months
3 or 10 months ago is not what's relevant in this
4 trial. It's what that jury has heard. And what we
5 could do then, some of those things, we have no
6 burden to do anything on. Most of them are not even
7 our issues. We could care less at that point in
8 time whether we had somebody that was going to say
9 Joe Nunnally went to somebody to get a prescription
10 for nicotine gum. That's not our issue. That's
11 their issue, that he should have somehow quit
12 smoking.

13 So we didn't have any evidence about it.
14 We didn't develop anything about it. We were under
15 no burden to develop anything about it. If they
16 want to put on evidence of something, if they want
17 to prove the negative, that's up to them. But they
18 can't do it with us, because it's not our issue.
19 But mainly, they're just not facts.

20 MR. DAVID: I have --

21 MR. MERKEL: The discovery statutes,
22 rules dealing with requests for admission
23 specifically point to factual matters, historical
24 facts that are not in dispute. And the state of
25 evidence is not a historical fact, Your Honor.

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1 MR. DAVID: May I have a minute?

2 JUDGE CARLSON: Mr. David.

3 MR. DAVID: As the author of those stupid
4 things, I perhaps -- I think, Your Honor, if they
5 admit that they have no evidence of a certain fact,
6 then -- they think they cannot deny the fact. So it
7 seems to me that they -- that they then admit --
8 essentially admit the fact. So that's why they're
9 drafted that way. And -- and I think they're
10 entirely appropriate drafted that way. But then
11 again, I would say that since I drafted them.

12 MR. ULMER: Your Honor, Charlie is -- is
13 not correct. I started to say wrong, but I figured
14 that would be too impolite. Rule 36 says "That a
15 party may serve on any other party written request

16 for admission of the truth of any matter within the
17 scope of Rule 26 set forth in requests that relate
18 to statements or opinions of fact or the application
19 of lawful to fact, including the genuine documents."
20 I don't think Rule 36 is restricted as the Court
21 suggested. But again, I've had my say, and if the
22 Court's ruling -- it's what the ruling is.

23 JUDGE CARLSON: I feel, you know, very
24 strongly that -- the way this needs to come about.
25 The ultimate filter, of course, all the Rules of

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1 Evidence we have and Civil Rules of Procedure, and
2 the ultimate filter through all of this -- all of
3 this has to flow through would be Rule 403. You
4 know, although relevant evidence may be excluded,
5 probative value substantially outweighed by the
6 danger of unfair prejudice or confusion of the
7 issues or to mislead the jury.

8 I think that's what would happen here.
9 Whatever probative value this might have would be
10 substantially outweighed by danger of unfair
11 prejudice, confusion, misleading the jury. So if I
12 marked these correctly, I believe -- let me go at it
13 from the standpoint of what would not be excluded.
14 It appears that request number 37 in the response
15 would be appropriate to read, as well as request
16 number 121 and request number 134. And then the
17 others would be excluded if I -- I think that would
18 be the appropriate way to deal with it.

19 MR. ULMER: Thank you, Your Honor. Could
20 I have marked for identification purposes the
21 partial document that was tendered to the Court?

22 JUDGE CARLSON: Yes.

23 MR. ULMER: In fact, there were two.

24 JUDGE CARLSON: I'm sorry, right. I
25 didn't do the other one. The one I just referred to

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1 was 490, and 491 appears -- let me make sure here.
2 Like request number 108 would be appropriate in the
3 response if I've read that correctly, and the other
4 two would be excluded.

5 MR. ULMER: And we will tender, for the
6 record, 490 and 491 for identification purposes
7 only, Your Honor.

8 JUDGE CARLSON: Let them be marked for
9 the record.

10 (Exhibits 490 and 491 marked for
11 identification.)

12 MR. ULMER: Thank you very much, Your
13 Honor.

14 JUDGE CARLSON: Anything further at this
15 point?

16 MR. MERKEL: Have a good weekend, Your
17 Honor.

18 JUDGE CARLSON: We'll stand in recess
19 until 8:30 Monday morning.

20 (Time Noted: 4:40 p.m.)
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